

**Illinois Department of Human Services  
Strong Foundations Partnership  
Maternal, Infant and Early Childhood Home Visiting Program  
HRSA-11-187  
9/30/2011 – 9/29/2012**

**PROGRAM NARRATIVE**

Illinois considers the formula funding available through this opportunity as short term or, in other words, available for one year. The following application reflects the intent of the Illinois Department of Human Services (IDHS) to further the implementation of its State Plan for Maternal, Infant and Early Childhood Home Visiting. Specifically, IDHS proposes to build the infrastructure of its home visiting network through training, technical assistance and information collection and transfer.

**Introduction to Home Visiting in Illinois**

Governor Quinn recently established an Office of Early Childhood Development. This office provides overall coordination and policy leadership for the development of an integrated system of early childhood services. The Project Director for the Maternal, Infant and Early Childhood Home Visiting Program (MIECHVP) is based in this office. This person also directs Illinois’ “Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment” (EBHV) grant. In Illinois, this project is known as “Strong Foundations,” while the MIECHVP project is known as the “Strong Foundations Partnership.”

Three organizations are primarily responsible for funding home visiting programs in Illinois. The Illinois Department of Human Services (IDHS), which serves as the lead agency for MIECHVP, has provided financial support for 37 Healthy Families America (known in Illinois as Healthy Families Illinois) programs. The Illinois State Board of Education’s (ISBE) Division of Early Childhood Education provides financial support for 104 Parents as Teachers programs, one Healthy Families Illinois program and one Nurse-Family Partnership (NFP) program. (This NFP program is also supported by local funds.) The Ounce of Prevention Fund, which operates as a public-private partnership, combines private resources with state funds from the IDHS to operate the Parents Too Soon (PTS) program. PTS, which began in 1982 as a gubernatorial initiative to reduce teen pregnancy, now operates 20 home visiting programs across the state. Nine PTS sites use the Healthy Families America model, nine use the Parents as Teachers model and two use the Nurse-Family Partnership model. The Ounce of Prevention Fund acts as an intermediary for the state, using public funds for program operations, and private funds to seed innovation and program development. IDHS and ISBE also provide financial support to the Ounce of Prevention Fund to operate the Illinois Birth To Three Institute, which trains local staff from all state-funded home visiting programs. ISBE also provides financial support to the Ounce of Prevention Fund to operate the Parents as Teachers State Office. Responsibility for managing grant awards for local program operations remains with the funding agency. In addition, the Administration for Children and Families of the U.S. Department of Health and Human Services (HHS) provides federal funding for a total of 30 Early Head Start programs in Illinois, of which 28 currently provide home visitation services. This information is summarized in Table 1.

Table 1 Number of Evidence-Based Home Visiting Programs by Funding Source: Illinois, 2011				
Funding Source	Home Visiting Program Model			
	EHS	HFI	NFP	PAT
IDHS		37		
ISBE		1	1	104
Ounce of Prevention Fund		9	2	9
USDHHS	28			
Total	28	47	3	113

These organizations, along with Voices for Illinois Children, a leading child advocacy organization, the Illinois Department of Children and Family Services (Illinois’ child welfare agency), the Illinois Department of Healthcare

and Family Services (which operates the All Kids and FamilyCare programs<sup>1</sup>) and the Illinois Coalition Against Domestic Violence comprise the Strong Foundations Partnership.

The Strong Foundations Partnership supports and is supported by the Home Visiting Task Force. The HVTF, led by its Executive Committee, serves as the convening, policy-setting, and decision-making body for the Strong Foundations Partnership. The Task Force is a standing committee of Illinois' Early Learning Council. The council was created by state statute in 2003 and also serves as Illinois' State Advisory Council on Early Childhood Education and Care authorized by the Head Start Act.

Three strategies comprise Illinois' proposed approach to the implementation of MIECHVP:

1. Expanding or enhancing one or more of five evidence-based models of home visiting;
2. Ensuring that the home visiting program is effectively connected to community-based organizations and services required to achieve the benchmarks; and
3. Further developing and strengthening a statewide system of evidence-based and innovative approaches to home visiting and the state and local infrastructure necessary to support effective service delivery. This will include the development and testing of a system of universal screening and coordinated intake and the enhancement of an early childhood collaborative in each target community.

***Section 1: Identification of the State's targeted at-risk communities:***

Selection of Target Communities. The MIECHV needs assessment identified 30 communities in three geographic clusters of ten communities each: ten community areas in the city of Chicago; ten townships or cities in suburban Cook County and the surrounding "collar counties;" and ten counties in the balance of the state.

The Executive Committee approved the following communities for the FY2010 Implementation Plan. The methodology underlying the selection is discussed in the FY2010 Implementation Plan.

**1. Englewood, West Englewood and Greater Grand Crossing (Southside cluster).**

Strengths: While Englewood, West Englewood, and Greater Grand Crossing have many needs and risk factors, they have a number of strengths. There is a sense of community among residents of these communities. Many families are long-time residents of these communities and work to better the community. Many grandparents provide a variety of support to the families. Some are raising their grandchildren and are active in early learning activities. These communities are experiencing revitalization and economic development. The churches and faith-based services in the community continue to be sources of support for many families. Public transportation is available.

Community groups have formed to address concerns. Teamwork Englewood, a local community development organization, has fostered many new initiatives and encouraged community collaboration. The Englewood Safety Networks Coalition is a network of community agencies that provide comprehensive and coordinated violence prevention activities for community youth. The Chicago Public Schools has invested in improving the schools in the community with support of after-school programs and the development of Community Action Councils. There are several high-performing high schools in the communities.

The availability of specialized medical services, including pediatric services, is a strength. Access Community Health Network has engaged specialized pediatricians from University of Chicago to provide services at its Grand Boulevard location. St. Bernard Hospital, located in Englewood, provides a variety of services to the community and is an important source of prenatal and pediatric healthcare. At its Englewood Neighborhood Health Clinic, the Chicago Department of Public Health provides a full range of primary health services to improve the health and

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<sup>1</sup> All Kids combines Medicaid, the State Children's Health Insurance Program and state funds to provide health insurance coverage for children. FamilyCare provides healthcare coverage to parents living with their children 18 years old or younger. FamilyCare also covers relatives who are caring for children in place of their parents. For more information, see IDHFS' web site, [www.familycareillinois.com](http://www.familycareillinois.com)

lives of community families. Services include case management, public health nursing, health education, prenatal and pediatric care, family planning, mental health services, parenting education for males, and WIC services.

The Illinois Maternal and Child Health Coalition, along with other partners such as the IDHS, the IDHFS, the March of Dimes and SIDS of Illinois, worked together on the “Closing the Gap on Infant Mortality”, a federally-funded initiative to reduce the gap in infant mortality between African American and Caucasian babies.

Six agencies operate eight home visiting programs in and around these three community areas, including:

- Henry Booth House, which operates a Healthy Families Illinois (HFI) program that serves an average of 80 clients per month. Two doulas in the HFI program serve 130 parents each year.
- Family Focus Englewood operates HFI and Parents as Teachers programs. The HFI program targets first time teen parents who are 13-19 years of age, living in Englewood, who deliver at St. Bernard Hospital. The PAT program targets parents of children 0-3 years old who are over 19 years old upon enrollment. Family Focus serves 65 participants in the target communities through HFI and 75 participants in the target communities through PAT.<sup>2</sup>
- True to Life Foundation operates a Parents as Teachers, housed in Englewood area public schools.
- Mercy Health Center is implementing a new Nurse Family Partnership program through Parents Too Soon.
- Children’s Home + Aid operates Early Head Start and Parents as Teachers programs with a capacity of 24 slots.
- Childserv operates a Parents as Teachers program with a capacity of 140 slots.

In addition, the Chicago Department of Public Health’s public health nurses provide in-home case management and nursing services as a part of the state’s and city’s Chicago Family Case Management and High Risk Infant Follow-up programs. The caseload for the home visiting programs in 2010 was 9733 which is 75% of the targeted caseload. Caseloads for Public Health Nurses are 155 active cases per PHN in the CFCM program, although some case managers handle as many as 250 cases per month. In 2010, CDPH received 3,439 infant and 254 maternal high risk referrals in the Adverse Pregnancy Outcomes Reporting System program. (These in-home services do not follow one of the evidence-based home visiting models selected for MIECHVP.)

Needs: These three communities are impoverished: between one in three and one in five families had incomes below the federal poverty standard in 2009 and the proportion of single-parent household was similar. More than 85 percent of the births in these communities are financed through Illinois’ Medicaid program. Between 16 and 17 percent of the newborns in 2008 had low birth weights, more than 90 percent of all infants were born to single mothers and between 10 and 12 percent of all infants were born to a mother who was less than 17-years-of-age. Ninety-seven percent (97%) of the community’s population is African-American.

The need for early childhood services in this area significantly exceeds the current capacity of existing programs. According to the Illinois Early Childhood Asset Map, there are 16,514 children under the age of 5 living in the target communities. Of these, 15,492 live below 200% of the poverty level, and 6,774 live below 100% of the poverty level. The existing early childhood capacity in the communities, including Preschool for All, Head Start, Early Head Start, licensed and license-exempt child care centers, family child care homes and home visiting programs, can serve only 6,227 children (38% of the community’s children under 5).

The need for home visiting and other intensive programs to serve the highest-risk infants and children is even greater. There are 4,360 children ages 0-3 who live at or below 100% of the federal poverty line, dramatically exceeding the community’s current capacity to serve high risk pregnant women and young children. The existing home visiting capacity of 356 slots and Early Head Start capacity of 111 slots can serve only 11% of the community’s highest-risk children.

The impact of this gap in services can be seen in the community’s poor maternal and child health outcomes. The communities have very high rates of low birth weight, infant mortality, and premature births, and a smaller

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<sup>2</sup> The HFI services are provided as a part of Parents Too Soon; the PAT services are supported by the Chicago Public Schools with Early Childhood Block Grant funds from ISBE.

percentage of women in the target communities receive prenatal care in their first trimester, compared to Chicago as a whole. The communities' rates of child abuse and neglect are twice that of Chicago on average, indicating a strong unmet need for parent education and support. The target communities have some of the highest rates of crime and domestic violence in the city of Chicago, and only 18% of adults in the community have completed some type of postsecondary education.

Existing mechanisms for screening, identification and referral. Family Focus receives referrals from: St. Bernard Hospital, where a positive screen has resulted; from the Department of Obstetric and Gynecology prenatal clinics, when mothers in the last trimester are identified as eligible for HFI; from other Illinois HFI sites; and self-referrals through Englewood high schools. Mothers are identified as eligible using the Kempe assessment and the Edinburg Maternal Depression Screening. Children are screened using the Ages and Stages Questionnaire (ASQ).

Henry Booth House receives referrals from the city and state referral systems. Also referrals come from the partner Head Start sites, with which it has linkages. Major outreach and recruitment for HFI comes from the agency's own case management and WIC programs. HFI also conducts outreach at the area DHS office and clinics. Henry Booth House screens using ASQ, Kempe checklist, and Edinburg Maternal Depression Screening.

Children's Home + Aid identifies children and families who are eligible for Early Head Start through referral linkages and collaborating agencies that provide a range of services beyond early childhood education. The agency also recruits via flyers, brochures, and promotional materials with an explicit message about services for children with disabilities. Community Partnership Agreements with LEAs and local health clinics in each community promote recruitment of pregnant women, infants and toddlers who are or might be at risk of developmental delay or disability. Other specific recruitment activities include twice yearly outreach letters to relevant community partners, recruitment fairs, hosting community activities, and attending neighborhood functions. Children's Home + Aid screens using the ASQ and the Early Head Start eligibility checklist.

Referral Resources. There are a number of agencies that offer the ancillary services that home visiting program participants may need. The providers of these services include:

- 1) Mental health counseling: Ada S. McKinley Community Services; Beacon Therapeutic Diagnostic and Treatment Center; Beatrice Caffrey Youth Services; Chicago Department of Public Health (adult mental health, substance abuse interventions); Children's Home + Aid Society; Metropolitan Family Services; the Community Mental Health Services of Resurrection Health Care; Family Focus (mental health services for CEV); Henry Booth House; and the YMCA of Metropolitan Chicago (for treatment of sexual abuse)
- 2) Substance abuse treatment providers: Family Guidance Center of Chicago; Henry Booth House; Human Resources Development Institute; and the Women's Treatment Center (an active member of the Home Visiting Task Force)
- 3) Domestic violence: Clara's House
- 4) Homelessness: Chicago Department of Family and Support Services; Heartland Alliance (offers homelessness services housed in Family Focus Englewood); and New Moms
- 5) Family Case Management Services: Chicago Department of Public Health; Access Community Health Network; and Henry Booth House
- 6) WIC: Catholic Charities; Henry Booth House
- 7) Child and Family Connections (Early Intervention Services): Easter Seals; LaRabida Children's Hospital
- 8) Primary Medical Care: Access Community Health Network; Beloved Community Family Wellness Center; Chicago Department of Public Health; and Mercy Family Health Center.

Plan for Coordination. The community collaboration for MIECHVP has proposed a system of universal screening and coordinated intake for early childhood services. Participating agencies and outreach organizations will use a universal screening form to identify clients who may be eligible for home visiting services. The home visiting programs will continue to use their existing screening tools, as required by the evidence-based model. The screening and assessment tools used for MIECHP (e.g., the Edinburgh Perinatal Depressions Screening questionnaire) will be used to trigger referrals to other community agencies. Further analysis of the screening questionnaires will be conducted to identify items that can be used to “trigger” referrals for specific services.

Integration of Home Visiting and Other Services. The organizations that participated in developing the community’s presentation have proposed a governance structure. It is comprised of a Steering Committee and four standing committees. The standing committees are: Training and Outreach; Community and Consumer Engagement; Program Evaluation; and Service Delivery. The Steering Committee is comprised of the co-chairs of the standing committees and other community stakeholders.

## **2. The City of Elgin**

The city of Elgin is located in Kane County, approximately 38 miles northwest of Chicago. Elgin has a total population of 102,590 residents, based on the 2005-2009 American Community Survey. There were approximately 23,500 families in 2009; nearly nine percent of them lived on incomes below the federal poverty standard. Forty percent of the population is Latino. The city has approximately 9,000 children under six years of age.

Strengths. A key community partner, the Elgin U-46 School District offers many assets for young children and early learning. An incremental school readiness program is in place. The District’s graduation rate at the high school level reveals strength. At 88.5% in 2008, it was higher than the average for the state of Illinois. The District has an aggressive school improvement plan and is dedicated to bringing students the best education possible. Another group dedicated to helping Elgin students is *Project Access*, which helps students who are homeless and give them the support and resources they need to succeed not only at school, but also at home. They help parents with filling out forms and acquiring medical, dental, and vision care for their family.

The United Way of Elgin has a strong community presence and maintains the Kane County Guide to Community Services, an on-line source of information on health and social services. There is a strong faith-based support community in Elgin.

Members of the Elgin Circle of Wise Women empower residents to lower infant mortality rates among African-American women; the Elgin YWCA provides support and outreach to the Asian and Laotian communities. The Grand Victoria Foundation (supported by proceeds from a riverboat casino) forms partnerships with organizations that strengthen educational opportunities for children and adults and boost the economic vitality and environmental health of the area. The Gail Borden Public Library provides reading groups for children starting at age nine months, and activities for children during school holidays and summer vacation and adults learning English as second language..

Needs: The need for home visiting services in Elgin considerably exceeds the supply. The IDHFS reports 2,099 births in 2009 to women who listed an Elgin zip code and also gave Elgin as their residence. Of these, 1,161 (55%) were financed by Medicaid. This suggests that there are about 3,500 Medicaid-eligible children between birth and three years of age in Elgin. Since there are only 186 home visitation slots available, only five percent of families can be served. A more conservative estimate of unmet need can be derived by applying a recent estimate of risk to the number of Medicaid-eligible births. A study of Family Case Management program participants (nearly all of whom are Medicaid-eligible families with a pregnant woman or an infant) conducted in 2010 by the Kane County Health Department found that 28 percent were determined to be at-risk. Applying this percentage to the 2009 Medicaid-insured births, there are 322 at-risk families with a newborn each year. Assuming that an equal number of at-risk, Medicaid-insured births occur for each of three successive years, a total of 966 at-risk families are in need of home visitation at any given time. By this estimate, only 20 percent of the need is being met by the existing home visitation programs.

Existing home visiting services: Currently only three Home Visitation Programs exist in Elgin: District U-46 Parents as Teachers, Early Head Start, and the Kane Kares Nurse Family Partnership Program. Capacity is very limited and has decreased recently due to reduced funding.

The Kane Kares Nurse Family Partnership Program serves very high risk families with first-time low-income mothers. The program can serve 36 families. Two-thirds of the current participants are teen-aged mothers; 87 percent are Latino and two-thirds are in school or have less than a high-school education.

The Early Head Start program serves low income pregnant mothers and parents of children ages 0-3. The program can serve 50 families. Most (55%) of the parents currently participating in the program are between 20 and 29 years of age; 80 percent are Latino and nearly half (43%) have less than a high-school education.

The District U-46 Parents as Teachers program serves high risk pregnant mothers or parents of children ages 0-3. The program can serve 110 families. Most (42%) of the parents who are currently participating in the program are teens; most (61%) are Latino and most (61%) are in school or have less than a high-school education.

Existing mechanisms for screening, identification and referral: Home visiting enrollment programs is coordinated through the Kane County Home Visitation Committee (HVC), created in 2000 to coordinate activities among nine home visiting programs in the county. The HVC pooled efforts and resources at the system level. A centralized referral process was created and implemented utilizing FCM<sup>3</sup> intake appointments with newly expectant mothers as a key access point, since 95% of Medicaid-eligible mothers entered the ECS system through FCM. Though the HVC was a county-wide group, the Elgin partners collaborated together on the unique aspects of their community needs and contributed to the effectiveness of the larger group as well.

A voluntary effort from the beginning, the HVC was formed with representation first from the existing HFI, NFP and PAT programs in Elgin and Aurora. Soon Early Head Start, the Day One Network CFC,<sup>4</sup> FCM, and the High Risk Infant Follow Up<sup>5</sup> program joined with the support of the FCM and TPS<sup>6</sup> programs.

Since the need for home visitation was so great and the resources so few, the HVC's initial goal was to assure that all home visitation programs received adequate referrals to always stay full and to avoid any duplication of services. The HVC created a centralized home visitation referral system in response to this need. At FCM intake interviews, mothers were offered the opportunity to receive home visiting and the FCM case manager obtained consent to make the referral and identified all the risk criteria that had emerged through the intake interview. The referrals were collected by the HVC Facilitator, recorded in a tracking database, and distributed among all the programs according to their eligibility criteria, the mother's residence, and the program capacity.

The HVC referral process mechanisms have evolved and improved over time, changing as often as system changes occurred. Just this year, the HVC revised the referral form in light of the recent reorganization of FCM within the county, reviewed joint policies to prevent duplication, and committed to a new referral tracking system to document the disposition of referrals.. Opportunities to shadow home visitors on a home visit will be offered to further engage the new FCM case managers in the critical process of promoting home visitation. This is especially important for high risk clients who may fear visits may be punitive.

Collaborative goals and activities beyond a centralized referral process were implemented as the Home Visit Collaborative developed: 1) use of a common referral form for all HV programs; 2) unified home visitation marketing/promotion materials were created in addition to materials produced by each program; 3) shared workforce development trainings were offered to all HV program staff based on HVC members input; 4) active participation in AOK assessment, strategic plans, and initiatives; 5) specific HVC action plans were developed to address ECS/AOK

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<sup>3</sup> Family Case Management, a statewide Title V initiative to reduce infant mortality through case management.

<sup>4</sup> Child and Family Connections, the regional intake system for Part C Early Intervention services.

<sup>5</sup> Infants identified through Illinois' Adverse Pregnancy Outcomes Reporting System are offered five home visits by a public health nurse during the first two years of life.

<sup>6</sup> Teen Parent Services, a statewide Title V program to support low-income teen parents.

goals and objectives; 6) participation in the County Community Health Assessment; followed by development/implementation of specific HVC action plans to address identified needs.

**Referral Resources:** Elgin has several providers of mental health services, including Ecker Center, Family Service Center of Greater Elgin, Catholic Charities, Kairos Family Center, Larkin Family Counseling Center, Lutheran Child and Family Services, Northwest Behavioral Resources and Sherwood Behavioral Health. The Family Service Center and Larkin Family Counseling also offer substance abuse treatment. Emergency mental health response for Medicaid-eligible clients is available, but access for low income, non-Medicaid eligible postpartum mothers is limited. Matching need with MH/SA capacity has been a longstanding challenge for Elgin.

Workforce development and ECS/AOK initiatives have increased capacity among home visitors and other ECS professionals to screen for maternal depression and infant social-emotional health. The AOK Network's partnership with the IDHFS' ABCD<sup>7</sup> project improved screening rates by collaborating with Kindergarten Round ups to promote 0-3 screenings and by encouraging primary care providers to use objective screening tools in their practices. AOK representation on the Kane County Mental Health Awareness Committee assures that MCH mental health needs and activities are carried out, such as —*Say It Out Loud*<sup>8</sup> and active participation with the Illinois Children's Mental Health Partnership.

One of the HVC members serves on the board of the Community Crisis Center, which provides domestic violence services in Elgin and northern Kane County. Workforce training on domestic violence screening --and intervention upon disclosure—has reached home visitors and other early childhood workers. Intimate violence studies have been conducted in collaboration with two HVC partners.<sup>9</sup>

Health services for low income pregnant women, infants, and young children are widely available, regardless of insurance eligibility, since two community health centers provide care. Dental care is offered by one community health center and the Well Child Center in Elgin. In addition, a Kane County Dental Coalition coordinates the delivery of dental sealants in the schools by several sealant providers and requires referral and linkage for children who need treatment. Nutrition services through WIC are offered by the Well Child Center and are co-located with the community health centers and the FCM programs.

**Plan for coordination:** The existing mechanism for coordinating intake among the community's home visiting programs will continue. The HVC members have discussed the advantages of enhancing the current centralized referral system into a truly universal system using the FCM referral process, form, and outcome tracking mechanisms together with other common referral entry points in the schools, hospitals, social service agencies—even online self-referral. This would assure that there is “no wrong door” for home visitation referrals.

**Capacity for System Integration:** The Elgin community is home to a vibrant, comprehensive, proactive Early Childhood System (ECS). Effective early childhood systems are marked by the obvious presence, easy access to, and community awareness of four major categories of services: 1) Early Learning –both at home and in the community; 2) Family Support—for the developing parenting role and for economic self sufficiency; 3) Health (including mental health) and Nutrition; and 4) Early identification, early intervention, and services for special needs children. The Elgin ECS is well-developed in these four service categories and is designed to be culturally and linguistically competent, family-centered, strengths-based, individualized, and coordinated across the four categories. The Elgin ECS frequently collects data, plans improvements, and evaluates outcomes. The Elgin ECS infrastructure has four key, interlocking components: The All Our Kids Birth-to-Five Network (AOK Network), the Perinatal Committee, the Breastfeeding Coalition, and the Home Visitation Collaborative.

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<sup>7</sup> Assuring Better Child Development, a project of the National Academy of State Health Policy, supported by a grant from the Commonwealth Fund.

<sup>8</sup> A public information campaign of the Illinois Department of Human Services and the Illinois Children's Mental Health Partnership to reduce the stigma associated with mental illness.

<sup>9</sup> Community Crisis Center participated in one of four “Developing A System of Care to Address Family Violence During or Around the Time of Pregnancy” grants awarded nation-wide by the federal Maternal and Child Health Bureau.

The members of Elgin's ECS are actively engaged in the county-wide AOK Network, which began in 2000. AOK exists to enhance county-wide ECS strengths, assess unmet needs, and develop assets to meet those needs through collaboration and coordination. Development of cultural competence among AOK partner agencies and their workforce is a key driver of community engagement and effectiveness. Not only is culture respected by assuring linguistic competence and staff reflective of the community we serve, attention and training about the culture of poverty has also been an AOK focus. Outreach to minority community members is strategic and ongoing. Elgin AOK partners include many programs of the U-46 Elgin School District, the multiple U-46 parent/community Advisory groups, the City of Elgin, the Elgin United way, the Gail Borden Library, the Hispanic and African American Coalitions and groups, two community health centers, private sector health providers, the Elgin WIC and Family Case Management programs, child care centers, a domestic violence agency, home visiting and early childhood center-based programs, substance abuse, mental health, dental health, and early intervention providers, the faith community, and many more.

### **3. Macon County**

Strengths: Macon County is located in the center of Illinois in the heart of the agricultural community. Agencies within Decatur and throughout the larger community work collaboratively to address the social, emotional, and educational needs of its citizens. The Macon County area is a diverse community as the multi-national businesses attract families from throughout the world in their work places.

Macon County agencies, school districts, and community businesses have a long demonstrated history of collaboration to enhance the quality of life for residents of Macon County. This organized collaboration approach can be traced back to the 1980's at which time the county established a consortium of agencies, schools, and businesses that continues to function to share ideas and information. This consortium works collaboratively on several county wide grants and initiatives. The county has an active Local Interagency Council addressing Early Childhood challenges, especially for the developmentally delayed. The county responded to various initiatives from the State of Illinois by establishing Child and Family Connection #18, the All Our Kids Early Childhood Network, and the Early Childhood Education Consortium. Early childhood agencies have been serving the community for many years: Head Start for over 45 years; Baby Teaching Activities for Learning and Knowledge (Baby TALK), which originated in Decatur, for over 25 years; the Decatur Public Schools 0 to 3 and 3 to 5 year olds programming for over 20 years; Macon Resources for over 20 years. In addition, Macon County Health Department's birth-to-5 prevention programs have been in place for over 20 years.

These long standing collaborations, as demonstrated by Human Service Agencies Consortium, Local Interagency Council, EDCO, Obesity Coalition, Asthma Coalition, Autism Support Group, Homeless Council, Breastfeeding Task Force and Early Childhood Consortium exemplify the community's efforts to work collaborative for the better health and education of families in the community.

The breadth of this collaboration is illustrated by the involvement of the judiciary. The Macon County State's Attorney has developed a mental health court, a drug court and a teen peer court. The teen peer court is one of only a handful operating in the United States. It applies the principles of balanced and restorative justice to build a sense of community for defendants. Additionally, a Child Advocacy Center has been created to reduce trauma for children who are victims of violence. The Illinois Department of Corrections' Women's Division Center in Decatur has implemented infant-parent programming to support inmates with young children.

The availability of medical services is a community strength. Macon County is ranked 6<sup>th</sup> in the Illinois County Health Ranking in the area of clinical care services. The Community Health Improvement Center, a Federally Qualified Health Center, serves low-income adults and children. The Macon County Health Department houses a dental clinic for low income children and emergency services for adults. There are two state-of-the-art hospitals within the county. Women are provided opportunities for prenatal care at two locations.

Decatur, Macon County's seat of government, is primarily a manufacturing community with a large contingent of service-oriented businesses. Two companies Tate and Lyle and Archer Daniels Midland are major players in the global agri-business market. Other large employers in Macon County include Caterpillar, Inc, Pittsburgh Plate



Glass, Ameren (a utilities company), and the school districts servicing each community. Additionally several hospitals and their satellites comprise the second largest employers in Macon County.

Needs: Macon County was identified as a potential target area in the original MIECHVP Needs Assessment. The county's population was estimated to be about 108,000 in 2009, with nearly 8,300 children under six years of age. More than seven percent of families live on incomes that fall below the federal poverty standard and nearly 10% of households are headed by a single parent. African-Americans comprise about 15 percent of the county's population. Slightly more than 1,400 births occurred to Macon County residents in 2008; nearly two-thirds (62%) of them were financed by the Medicaid program; more than half (53%) were born to single women and five percent were born to mothers under 17 years of age. The estimated rate of maltreatment of children under five years of age was 26.7 per 1,000 children in 2008.

Decatur suffers from a high unemployment rate with many families having to access services for the first time. According to the Bureau of Labor Statistics, the unemployment rate for Decatur for the month of February 2011 was 11.2 percent -- well above the state rate of 8.9 percent for the same period.

Existing home visiting services: There are six home visiting programs in Macon County: two PAT programs supported by ISBE; one HFI program supported by IDHS; an Early Head Start program, and two programs that use the Baby TALK model. The Parents as Teachers programs serve a combined total of 355 families, the HFI program serves 68 families and the Early Head Start program, 22. Two PAT programs have closed since March 2010; 80 families lost services as a result.

Existing mechanisms for screening, identification and referral: Currently each home visiting program has an individualized screening tool. Several key elements are included in the screening process for all home visiting agencies: family risk analysis, health history, developmental screening, and personal interview. Families and children are identified in several ways: media advertising; screening days at area schools, libraries, and daycares; births at county hospitals and regional high risk birth centers; DCFS and related child welfare agencies; flyers; medical card recipients notification to health department; referrals from schools, physicians, pregnancy centers, and the health department; pre-school parent questionnaires; school registration forms; WIC; and word of mouth.

Although several locations and methods are utilized to promote programming and identify potential clients, once identified, there is a range of referral processes. Commonalities exist in the priority identifiers, parent interviews, and informal observation. If the informal observation with the child indicates immediate follow-up, this is addressed. The home visiting programs do not currently utilize a central intake and referral process, however they do meet monthly to ensure there is no duplication in services.

Referral Resources: Women are screened for perinatal depression by several community agencies. The Mental Health Board has partially addressed this increasing need by placing counselors from Heritage Behavioral Health Center, in the FQHC and the Macon County Health Department, as well as its own facilities. The New Life Pregnancy Center and private mental health counselors also provide counseling services. Group sessions and workshops are available for families. However, more family mental health services are needed.

Substance abuse treatment providers include Heritage Behavioral Center and St. Mary's Hospital. Support for families such as parent education, referrals and screening dealing with these issues comes from Baby TALK, Health Department, CHIC, Parents and Teachers Programs and Early Head Start. These services are currently being prescribed through the Mental Health and Substance Abuse Court utilizing Dove/ Heritage family services centers assisting parents and providing healthy environments for children.

Domestic Violence is initially addressed by a protective residential program for mothers and their children by Dove and followed with additional counseling support through Dove family sessions, Growing Strong Sexual Assault Center and Safe from the Start. Dove and Growing Strong provide a 24 hour crisis hotline.

Agencies such as Soyland Access to Independent Living (SAIL), Starting Point at the Macon County Health Department, Prairieland Service Coordination, Step Forward and Macon Resources, Inc. provide case management, training sessions and transitional support for developmentally delayed parents. Life skill training and teen parenting

classes are also provided through local high school special education departments, health department, Office of Rehabilitation.

Coordination of homeless services is provided by the Homeless Council. Day Services, temporary housing, and long term housing are provided by the Decatur Housing Authority, Homeward Bound, Grace House, Salvation Army, Virtue House, Men's Shelter, Oasis, God's Shelter of Love, and Heritage Behavioral Health. Good Samaritan Inn provides free lunches seven days a week. The Decatur Park District provides breakfast and lunch to children throughout the summer.

Multicultural services are provided by home visiting programs and the local school districts including bilingual home visitors and bilingual classrooms. Baby TALK, in conjunction with Richland Community College, provides a Family Literacy English as a Second Language program for adults. Decatur Public Schools, Johns Hill Magnet School, provides bilingual classrooms and family support for multicultural families. The local hospitals and health department utilize the state bilingual help line.

Plan for Coordination: In order to continue to support three separate models of home visiting while consolidating and managing a collaborative consortium, the providers will join into an association to monitor and maintain a formal process of referrals. Each entity will continue to identify and screen families and assign as appropriate to their programming. Families who do not qualify for the organization administering the screening will be brought to the consortium for review. These families will be referred to another member of the consortium or to one of the area family resources liaisons for additional follow-up. The area liaisons will then further assess and determine referrals to the most appropriate agency or organization. Initially, the Consortium will meet on a weekly basis so as to make decisions in a timely manner and to avoid allowing any child to drop through the cracks.

Capacity for Integration: Integrating these home visiting services into an early childhood system is a task which the Macon County agencies, community businesses, school districts and the Decatur Area Education Coalition (EDCO) is prepared to undertake. EDCO focuses on Kindergarten readiness, daycares, and services available to prenatal families up to 3 years of age.

#### **MIECHV FY11 Formula Grant Community Selection**

In order to further expand evidence-based home visiting in the most at-risk communities, the Home Visiting Task Force Executive Committee selected the following three additional communities bringing the total to six

#### **4. Cicero**

Strengths: Adjacent to the western border of Chicago, Cicero is one of the oldest and largest municipalities in the state and the only incorporated town in Cook County. Cicero is located just west of the city of Chicago's. Approximately 85% of Cicero's population is Latino, primarily of Mexican descent.

The community strength is its understanding of the importance of working together to make community-wide change. The community has come together in the form of non-profit service providers, public agencies, medical professionals and parent councils. A Community Team is comprised of many dedicated organizations and individuals that have been committed to coordinating services in the Cicero area for nearly 30 years. In the 1980s, some participated in the Children and Youth Coalition of the Berwyn-Cicero Area. Initially focused on teen pregnancy issues in Berwyn and Cicero, the coalition evolved over time to address a broader youth agenda in both communities.

In 2004, several of the participating agencies created the Cicero Youth Task Force (CYTF), a volunteer coalition of over 40 individuals and organizations dedicated to the wellbeing of youth and families in Cicero. In the past seven years, the CYTF has grown to a network of over 200 members representing school districts, local social service agencies, police, government, civic groups and citizens. The members have achieved much success by working collaboratively. Since its inception, CYTF members have secured more than \$20 million in funds for initiatives designed to increase parent involvement, expand youth opportunities, improve health outcomes, and foster community safety. Funders of the task force include United Way.

In addition, several of Cicero community team members participate in the Safe from the Start Coalition, a network of public, private, and nonprofit partners committed to assisting children and their families impacted by violence in Building a Coordinated System of Home Visiting and Early Childhood Services. The Safe from the Start coalition is one of only 12 funded by the Illinois Violence Prevention Authority since 2007 focusing on violence prevention

Needs: Families in Cicero face daily challenges relating to poverty and low income levels, lack of English language skills, single motherhood and teen parenting. Census data from the American Community Survey 2005-2009 estimates that 43% of Cicero residents were foreign-born. The census data also indicate that more than 80% of Cicero residents spoke a language other than English in the home, with Spanish being the language in 79% of households.

Cicero residents have faced more barriers to educational and employment opportunities than their counterparts in other western suburbs. In the 2005 survey, 42% of Cicero residents indicated they had not earned a high school diploma. Only 5.4% of Cicero residents had earned a college degree.

In 2008, the unemployment rate in Cicero was 8.2%. Given the economic crisis, the unemployment rates are likely even higher today. According to 2008 estimates for Cicero, 68% of children under the age of five live in households at or below 200% of the Federal Poverty Level. This means that almost 7 out of 10 young children in Cicero are living in poverty.

Approximately 15% of all births in Cicero are to teen mothers, almost twice the percentage of births to teens in Cook County, and over 87% under age five are on some form of public assistance (TANF, food stamps, Kid Care, AllKids, Medical). In addition, 56% of births were to single mothers, and more than half of all births in Cicero are to single mothers designated as heads of households.

Between 2000 and 2006, the percentage of babies born with low birth weights increased from 6.1% to 7.6%. In the same period of time, 41 children died before reaching their first year, primarily because of conditions relating to low birth weight.

In 2008, there were 11,232 children under the age of five living in Cicero. A report of child care providers and capacity in Cook County by Illinois Action for Children shows that in Cicero, there are only enough slots in Child Care Centers to serve 5% of the total under age five population. Only 10% of children under five were enrolled in Illinois State Board of education Pre-K program, and 1% and less than 1% were enrolled in Head Start and Early Head Start respectively. This means 90% of children in Cicero, under the age of five, or over 10,000 children, go without licensed child care or quality early childhood education.

As the primary mental health service providers in the area, Pillars and Family Service can attest to the serious need for mental health services to meet the growing number of children who reside in Cicero. Research shows that 1 in 5 children has a diagnosable mental health disorder, and 1 in 10 youth has mental health problems severe enough to impair how they function at home, school, or in the community.

Current Home Visiting Services: The existing home visiting programs serve less than 3% of the children under five in Cicero. The 293 home visiting slots available to families are divided as follows: 98 Early Head Start, 85 Head Start, and 110 Baby TALK. Though limited in capacity, these programs have been very successful in the community. For example, the Children's Center of Cicero/Berwyn Early Head Start (EHS) program has served families in Cicero for over 10 years with excellent program outcomes: retention, 96% of the children are up to date on immunizations, children have age appropriate TB blood screenings., and a high home visit completion rate of 85-90%. Services are coordinated across the city through a Cicero-wide agreement and referral tool.

Referral Resources: Several agencies serve children and families in the communities of Berwyn and Cicero providing mental health services and prevention services. Pillars, Family Service and Mental Health Center of Cicero, and Pilsen Wellness Center provide outpatient mental health services including school based services. Workers meet with children in the school and coordinate services with school staff. Pillars has contracts with the Department of Children and Family Services (DCFS) to provide counseling services to children and families with DCFS involvement. Riveredge Hospital and Hartgrove Hospital are the primary psychiatric hospitals for children in

Berwyn and Cicero. Riveredge has a day treatment program for children who do not need hospitalization but require more intensive services. Youth Crossroads and Corazon provide preventive and specialized services in the communities of Berwyn and Cicero. Youth Crossroads serves children at risk for or involved with the juvenile justice system. Corazon Community Services offers after school, mentoring and other supportive services for youth, including the Cease Fire program, an evidence-based public health approach to reducing shootings and killings. Youth Outreach Services provides addictions counseling services to youth living in Berwyn and Cicero. Each of these agencies, along with many others, is part of the Department of Children and Family Services (DCFS) Local Area Network (LAN) 58. Each LAN is comprised of service providers who work together to serve children and families within their own communities. LANs are responsible for ensuring the availability of services throughout Illinois. The LAN serves as a referral source for providers and consumers. Pillars co-chairs LAN 58 along with Youth Crossroads. The current focus of the LANs is to support school success for children.

Existing mechanisms for screening, identification and referral: This collaborative will adopt the Parents as Teachers (PAT) home visiting model. PAT is one of four models approved for the State of Illinois early childhood programs. PAT, through the Born to Learn curriculum, promotes early childhood parent education, family support, and school readiness based on the premise that "all children will learn, grow, and develop to realize their full potential." The program serves families throughout pregnancy until their child enters kindergarten. The model provides home visits carried out by professional staff trained and certified in use of the Born to Learn curriculum, which draws heavily on the science of child development, including brain development. Other required model components are group meetings to foster social networks and regular health and developmental screenings, with referral to a community resource network if needed.

## **5. Rockford**

Strengths: The Early Learning Council of the Rockford area was founded in 2003. Over the last seven years it has provided leadership in developing a vision for comprehensive early learning services for young children ages birth to five years old. City of Rockford Head Start is a founding member and an active participant in this collaboration.

Rockford has numerous strengths:

Education and child development services: Rockford Public Library, Discovery Center Museum, Rockford and Harlem Public Schools, Rockford Public Schools Parent Center, LaVoz Latina, Rock Valley College, Literacy Council, and the local Child Care Resource and Referral Agency.

Health and nutrition services include Crusader Clinic Winnebago County Health, Janet Wattles / Mildred Berry Mental Health Center, United Way, and faith based organizations in the Rockford area provide emergency food assistance.

Social Services: Rockford Human Services Department/Community Services Division, City of Rockford Human Services Department /Energy Division, Illinois Department of Human Services, Salvation Army, Rockford Rescue Mission, Rockford MELD, Rockford Township General Assistance, Rockford Housing Authority, Remedies Shelter

Needs: The central issue facing the city of Rockford is poverty, which must be addressed in a coordinated fashion, across multiple social, health and economic systems. To address it, the community will implement a system of care to promote optimal pregnancy outcomes and healthy early childhood development through the Maternal Infant and Early Childhood Home Visiting program. The MIECHVP will focus on the expansion of evidenced-based home visiting programs, and integrated solutions to meet individuals where they are at in their lives.

The poverty rates of both Winnebago County and Rockford are the highest in all of northwest Illinois. In Winnebago County, Census tract data helps to identify where the greatest needs exists, especially in the areas where poverty ranges from 40.1 - 61.2%. The poverty rate in the city of Rockford is 26.9% (2009), which represents a 92% increase in poverty since 1999. Likewise extreme poverty in Rockford is at 13.4% (2009), which is up 100% since 1999. Child poverty rates are considerably higher at 42.1% (2009) and growing at a slightly quicker rate over the past decade, 115%. According 2008 IECAM, there are 13,099 children ages birth – five living in the city of

Rockford. 4879 children live at the 100% level of poverty. Households with the greatest degree of poverty are female headed families with children 0-17 years of age, with 42.9% of such households in poverty (2006-2008).

Low birth weight is a major risk for infant death and later childhood health problems.

- Low birth weight levels are 8.8%, surpassing both Illinois and U.S. rates
- Almost twice as many black infants were low birth weight (13.8%) as white (7.8%) and Hispanic (7.1%)
- Black infants are 30-40% more likely to be born prematurely (less than 37 weeks gestation) than white or Hispanic infants

In 2010, 12.4% of all births in Winnebago County were to teen mothers vs. 10% for Illinois. Since 1995, teen birth percent has ranged from 11.2% to 13.3%. Higher levels occurred between 1980-1990. Poorer outcomes experienced by black mothers.

The infant death rate from 2002-2006 among blacks (18.4 per 1,000 live births) is triple that for whites (6.2) and Hispanics (5.4). Fewer black pregnant women received first trimester prenatal care (62.7%) than white (75.1%) or Hispanic (72.4%).

Births to unmarried mothers account for 50.3% of births in Winnebago County. Winnebago County has a number of interrelated factors that fall below the statewide mean of all counties. These include in part children in poverty, poor mental health days, and poor to fair health days, lack of social support, teen births, single-parent households, low birth weight births, poor high school graduation, and unemployment. With the latter being three standard deviations below the mean.

Winnebago County has experienced a gradual increase in the proportion of births that are low birth weight from 1980 to 2008. This is consistent with the same trend observed for the State of Illinois and the U.S. In the most recent four-year period (2005-2008), the proportion of births born low birth weight in Winnebago County average 9.5 % in comparison to the state of Illinois at 8.5% and the U.S. at 8.3%. The Winnebago County figure of 9.5% (low birth weight) represents a 13% increase over the previous five-year period (2000-2004) and a 46% increase over the 1980-1984 proportion of births born low birth weight.

Examining low birth weight (LBW) by race and ethnicity using five year averages (1980-2008), African American births in Winnebago County are 2.2 times more likely to be born at LBW than white infants and almost three times more likely than Hispanic infants, primarily due to prematurity (born before 37 weeks gestation) and fetal growth restriction. In Winnebago County 71% of LBW births are premature births (2003-2006).

The likelihood of LBW births also changes based on the mother's age and education. Mothers with a high school education or less are more than 1.5 times as likely to give birth to a LBW baby than a mother who has graduated from college ( $\geq 16$ ). Births to teenage mothers are almost 1.5 times more likely to be LBW than mothers who are in their 20 or 30's (2003-2006).

Approximately seven in ten pregnancies to unmarried women in their 20's are unplanned. Many unplanned pregnancies result in a birth having a significant consequence for both the child and the family as a whole, including poverty. Further research substantiates a strong link between the ability to plan pregnancies with decreased poverty and increased educational and workforce opportunities for women.

Existing Home Visiting Services: The following goal and integrated service components are based on the needs of the Rockford Community, with careful attention paid to the evidenced-based home visiting programs: Parents as Teachers; A universal access for high needs families, service intensity based on need. Healthy Families Illinois; Reduces family isolation, promotes healthy child development, and reduces child abuse and neglect. Early Head Start – Enhanced Physical, Social, Emotional, and intellectual development, assist in access to health care and supports parents role.

The principal goal of the Rockford MIECHVP initiative will be to provide early, continuous, intensive and comprehensive home visiting services to pregnant women in order to improve prenatal, maternal and newborn

health. It is Rockford's intent to facilitate improvements in child health and development, support parental roles, reduce domestic violence, and improve coordination of community referrals.

Current intensive home visiting programs serve less than 15% of the at-risk infants and toddlers in the community whose families' incomes are below the Federal Poverty Level. (Early Learning Council of the Rockford Area) These programs include the Rockford Public Schools Early Childhood program, Early Head Start, La Voz Latina, Easter Seals Children Development Center and the Winnebago County Health Department's Targeted Intensive Prenatal Program. Face to Face and Group Support Services are provided by agencies listed below.

Referral Resources: Through the activity of the Early Learning Council, local service providers, community members, and public/private entities we are involved in addressing a multitude of needs within the Rockford community. In addition, through the efforts of the Council, all entities have strong practices of collaboration in providing maternal child health programs, early childhood education and developmental programs, and services for infants, toddlers, pregnant women, and their families. Collaborative networks, as a whole, are very strong in the Rockford area.

Screening, Identifying and Referring Families: Target population: enrollment in new and expanded services will be prioritized based on the following risk factors; families living in poverty, parents of low birth weight babies; African American women, families following below the federal poverty guidelines, low education (high school education or less); and pregnant and parenting teens. A single point of entry process for the target service population will be implemented through the WIC program at the Winnebago County Health Department. Every WIC client will be referred for home visiting services based on the defined priority risk factors. Each client will be referred to the appropriate agency to meet their specific needs.

Selected Home Visiting Programs: It is proposed Healthy Families Illinois, Parents As Teachers, and Early Head Start will be expanded to increase the capacity for greater intensity of home visiting based on a universal intake and assessment process that would evaluate risks. This will be further supplemented by Winnebago County Health Department's targeted intensive prenatal (TIP) case management home visiting services, family case management and the women, infant and children food supplement (WIC) services. A critical analysis of the TIP case management program was undertaken by WCHD in 2008 in a retrospective cohort study covering a two-year period of (2005-2006). The results of this work indicated TIP services for high risk women leads to increased client contacts, increased prenatal visits to medical providers for pregnant women, and reduced LBW outcomes when seven (7) or more client contacts are achieved.

Plan for Coordination: The community providers of the Rockford MIECHVP propose to enhance coordination among home visiting programs and expansion of other early childhood services to ensure every family expecting, or has a newborn, is screened for services and referred to appropriate providers through a coordinated point of entry system through the Winnebago County Health Department, Crusader Health Clinic, and Rockford's local hospitals. In addition to creating a coordinated point of entry, the community of Rockford is uniquely positioned to further enhance early childhood services through the Early Learning Council of the Rockford Area.

Capacity for System Integration: Rockford is a community with numerous resources, yet these resources needed to be collected into a format that would be accessible to those in need. Through the commitment of the pre-natal to six committee, CAP4Kids was formed. CAP4Kids is a Children's Advocacy Project that is able to bridge the gap between those providing services and those in need of services. In Winnebago County, we have developed an electronic resource directory linking over 250 child-related service agencies through a single website with 21 specific categories. Agencies, hospitals, school district staff, medical facilities and physicians offices, teachers, and case managers are able to access necessary information for clients. In addition to meeting a specific need, the CAP4Kids project is further evidence of Rockford's community's readiness to; convene, identify, address, and implement solutions to significant issues in a short period of time.

## **6. Vermilion County**

Strengths: Vermilion County is a business and industrial hub for east central Illinois. Major employers include Auto Zone Midwest Distribution, Pepsico, Quaker Oats, Genpact – Walgreen’s national accounting center, the Veteran’s Administration Illiana Medical Center, School Districts, and Provena USMC Hospital Campus.

The urban public school system has embraced systems transformation with the assistance of Illinois State Board of Education and the resulting changes have been a force for uniting the community around the possibilities of meeting educational challenges. Urban and smaller county school systems are in the process of fully implementing Positive Behavior Interventions and Supports, including Response-to-Intervention.

Needs: Vermilion County has been struggling with substantial declines in employment, increases in poverty, a school system with high drop-out and expulsion rates, and low achievement in comparison to the State average (ICJIA, 2004). Vermilion County’s hub, Danville, was identified for having the lowest metropolitan home values in the nation (CNN, November 2006). This decline in property values has occurred due to a significant rise in unemployment over the past twenty years as a result of the loss of substantial employers including General Motors, General Electric, SBC, and others. Danville was placed on the Heartland Alliance “Poverty Warning List”, as the percentage of citizens living in poverty reached 23% (Heartland Alliance, 2010). The number of students receiving free and reduced cost lunch in Danville’s District #118 school system has risen to 75% (District 118, 2010).

Recently, Vermilion County was informed it was the fourth lowest county (98 out of 102) in the state by the County Health Ranking (Robert Wood Foundation 2011) in terms of the overall health of its citizens. The county has a high rate substance abuse, including use of methamphetamine and heroine,. The rate of substance-exposed infants in Vermillion County is also higher than most other counties in the State (ICJIA, 2004). Vermillion County has “... verified rates of child abuse and neglect 97 percent higher than in other urban counties.” (ICJIA, 2004). A 2008 map of the incidence of child abuse and neglect placed Vermillion County in the top tier (ICJIA, 2008).

The estimated unmet need related to provision of home visiting services to young families at risk is based on the percentage of Vermilion’s population eligible for services in relation to the number currently receiving services. Numbers were derived from US Census data for Vermilion County in comparison to numbers of children and mothers presently in home visiting programs. At present Vermilion County is serving only 7.2% of eligible children (0 to 3) in home visiting programs. Proposed program expansion eligibility is based on income less than 185% of the poverty level and the child being less than 36 months.

For children born to teen parents who are at highest risk for abuse or neglect and less able to enter kindergarten ready to learn, the community is currently serving only 15% of the eligible teen parent population. Services to fathers are equally underserved. Likewise, doulas are servicing just 15% of pregnant teens and no adults.

Vermilion’s overall unmet need for all eligible children 0-3 is almost 93%. Vermillion’s unmet need for those at highest risk is 85%. These numbers include families currently participating in programs with Parents as Teachers presently operating with fidelity to the model. An additional 2.5% of children are presently served in other home visiting programs in the community. Vermillion County’s home visiting program’s largest wait list only includes pregnant mothers or mothers with children less than six months. The community needs to expand services by 73% just to cover the unmet need for children under age six months on wait lists. Many on the wait lists are pregnant teens, pregnant mothers or teen mothers with children under six months who are at highest risk. Families with children over age six months are not added to wait lists since they do not presently qualify for services with current required program limitations. At present, community screening efforts do not even refer families in need if the child is over six months of age. Yet weekly, families are turned away with children at-risk for abuse, neglect or who are not able to offer an appropriate early learning environment as the child is over six months of age at inquiry for services.

Vermilion County is comprised of urban and rural, young and old, Caucasian, African American, and Hispanic. The population is 24% African American, 70% Caucasian and 5% Hispanic. Persons under 18 account for 25% of the population. The number of children under age five is 7.1% which is identical to the national average however; the percentage of persons living below poverty in Vermilion County is 23% which is over double the national average

(Heartland Alliance, 2011). In the smaller cities and rural areas, poverty shows a slight decline and minorities are less represented. However, these smaller cities and rural areas are still suffering from high unemployment and poverty rates above the national average.

A smaller percentage of the youth graduate from high school and Vermilion County has fewer college graduates in comparison to the national average (US Census). Many citizens lack health insurance and 34% are on Medicaid (Heartland Alliance, 2011). Needs of Vermilion County residents include employment, improved access to healthcare for the uninsured and underinsured, improved food sufficiency for the underemployed and low wage earners, energy efficient housing, reduced power bills, and safer neighborhoods. Youth are in need of expanded access to positive youth development opportunities and for older youth, the opportunity to gain work experience. At-risk parents are in need of additional supportive services, including expanded home visiting programs to ensure that Vermilion's most vulnerable children are given the opportunity to compete academically and enjoy positive social and emotional health.

Existing Home Visiting Services: Vermilion County has two evidence-based models in the community: Healthy Families Illinois and Parents as Teachers. The Center for Children's Services has two Parents as Teachers programs both delivering with fidelity to the national standards and one Healthy Families Illinois program. East Central Illinois Community Action and Danville District #118 both have Parents as Teachers programs that are close to fidelity to the national standards. All programs have a wait list and family centered initiatives within their programs. Community Action provides two socializations each month, lending toy and book library, health and developmental screenings; District #118 offers community support activities, Parent Café, play dates, parent education events, developmental screenings and health screenings. The Center for Children's Services (CCS) has Doulas, monthly consultation with a medical provider, lending toy and book library and four weekly groups: prenatal, infant, toddler and father's group. Each group provides transportation, dinner, child care, parent child activity and a psychosocial parenting class with topics such as depression, anger, conflict and stress management, domestic and child abuse awareness. Heart2Heart is a 12 week child sexual abuse prevention program offered once a year.

Screening, Identifying and Referring Families: The current mechanism for screening, identifying and referring families and children to home visiting programs is through community partners. Each program has multiple referral sources that provide the initial screening, most often based on income and age of the child, to determine appropriateness of the referral based on their knowledge of the programs. District 118's HOME program gleans its referrals from pre-kindergarten community screenings, and Child and Family Connections. East Central Illinois Community Action collects referrals from Child and Family Connections and DCFS. The Center for Children's Services primary referral source are WIC, Women's Care Clinic, Polyclinic, Carle Hospital, school social workers and nurses, obstetricians and interagency referrals. Once the referrals are given, the programs confirm eligibility and place the family on a wait list based on gestational age, parents age or child's age and known risk factors.

Referral Resources:

**Mental Health Providers:** Publicly funded mental health providers in Vermilion County include Crosspoint Human Services and The Center for Children's Services. Crosspoint provides adult crisis services while the Center for Children's Services provides mental health crisis services to children and youth up to age 21.

**Substance Abuse Treatment Providers:** Vermilion County has three publicly funded substance abuse treatment centers including Alcohol Chemical Evaluation Services (ACES), New Directions Treatment Center and Prairie Center Health Systems. Options for treatment include outpatient, intensive outpatient, pharmacological interventions for opiate addiction, and adolescent treatment services. All accept Medicaid and private insurance.

**Domestic Violence Programs:** Crosspoint Human Services programs address domestic violence including shelter for women and children, counseling, and assistance with orders of protection. ACES provides anger management counseling for court referred persons and provides domestic violence counseling.

**Homelessness Supports:** Homelessness support services include homelessness prevention programs at the Salvation Army, the Rescue Mission for adult men and veterans, Crosspoint homeless shelter for women and young children, domestic violence shelter, and emergency host-home shelter care for youth ages 11 to 17. Crosspoint Human



Services provides subsidized supportive housing and group homes for persons at-risk for homelessness with developmental or mental health disabilities.

**Service Providers Working with Families with Young Children:** Service providers who work with families with children under age six include the Vermilion County Health Department, WIC, DHS Public Aid / TANF, Child and Family Connection- early intervention program, DCFS, The Center for Children's Services, East Central Illinois Community Action Agency, CCRC – Child Care Resource Center, Danville District #118 school system, and multiple county school districts, Danville Housing Authority, pediatric primary care providers including Carle Clinic, Christie Clinic and many private practices, Vermilion County's Federally Qualified Health Center – Aunt Martha's, substance abuse treatment providers – Prairie Center Health Systems, ACES, and New Directions, Crosspoint domestic violence programs, Boys and Girls Club, and the YMCA.

**Selected home visiting program:** We are proposing to expand the community home visiting programs to substantially improve outcomes for a minimum of 25% of Vermilion's at-risk children ages 0 to 3. To meet this unmet need we would like to expand current programs by at least 200%. To preserve and build on the communities collaborative efforts, utilizing the PAT model allows for referrals, data collection and services to flow seamlessly between the three agencies. PAT has flexibility as to when a child can enroll in services due to their universal access model whereas HFI requires the child to be less than two weeks at intake and the first home visit must be delivered prior to the third month postnatal. Intake flexibility is important to serve the county's identified underserved populations since many of the community unmet needs are due to the ages of the child at intake.

**Plan For Coordination:** The community created Vermilion Advantage, a non-governmental entity charged with the task of assisting the community to respond to and overcome its economic and social challenges. Arising out of Vermilion Advantage, with the assistance of the Vermilion County Health Department and other entities, the community undertook the task of completing a strengths and needs assessment for the county's entire population from age 0 to seniors. The resulting consultation created desired goals for improvements, methods of measuring change, and identification of stakeholder entities within the community who stand ready to meet the challenge of achieving meaningful change. The group decided to place strategic attention to the early childhood initiative.

**Capacity for Systems Integration:** A key partner in the process of community improvement and identifying early childhood (0 to 6) as a time of paramount importance in relation to health, well-being, and later academic achievement has been the United Way and its Success By 6® initiative "Helping all children succeed for life." The community has embraced Success By 6® as a vehicle for bringing a unifying vision towards improving the early childhood system within the community.

Out of a desire to positively assist parents with safe parenting, Vermilion County has also participated in the Strengthening Families initiative "Love is Not Enough." Vermilion's Parent Café, supported by a diversity of programs and providers, has been recognized by the Illinois Department of Children and Family Services (DCFS) as being unique and unifying in its approach. To help address the needs of at-risk youth, Vermilion County provides multiple Teen REACH (after-school program)sites, Peer Court, Boys and Girls Club, Big Brothers Big Sisters, Y-Kids, 21<sup>st</sup> Century Community Learning Centers, Family Youth Services Bureau – Basic Center Program for runaway and homeless youth, Comprehensive Community Based Youth Services (CCBYS), Juvenile Justice, Unified Delinquency Intervention Services (UDIS), Reaching Out to Help- Violence Prevention Initiative, ATOD education, and adolescent substance abuse treatment services.

## **Section 2: Home Visiting Program's Goals and Objectives**

The goals and objectives for Illinois' Strong Foundations Partnership reflect four essential elements of our strategy: 1) operating home visiting programs with fidelity to their models; 2) developing strong referral networks for home visiting program participants in order to achieve the national benchmarks; 3) testing a universal screening and coordinated intake system; and 4) strengthening the early childhood service delivery system.

The goals and objectives are as follows:

**Goal 1: The statewide system of evidence-based and innovative approaches to home visiting and the state and local infrastructure necessary to support effective service delivery will be enhanced.**

- 1.1 Implement or expand evidence-based and innovative home visiting models and test service delivery enhancements in selected target communities.
- 1.2 A system to screen all pregnant women and families with newborns and link them to a full array of perinatal and early childhood services will be developed and tested in at least one target area.
- 1.3 The agencies and individuals in the target area who serve families with young children are organized into an effective and efficient service delivery system.
- 1.4 The state agencies that belong to the Strong Foundations Partnership will develop and maintain the staff capacity, information technology and partnerships required to support the operation of high-quality, effective home visiting programs.

**Goal 2: Home visiting programs operate with fidelity to national models**

- 2.1 Program staff meets the national model's education, experience and professional licensure requirements, reflects the cultural and linguistic diversity of the community they serve and demonstrates cultural competence.
- 2.2 Program staff completes the training required for their role in the project.
- 2.3 Program staff regularly receives reflective supervision
- 2.4 The home visiting program's caseload remains at or above 75% of capacity.
- 2.5 The home visiting program provides at least 75% of the expected number of complete visits for 75% of participating families.
- 2.6 The home visiting program collects information about its operation and uses that information to improve performance.

**Goal 3: Home visiting programs are embedded in the overall system of services for families with young children.**

- 3.1a Local home visiting programs will execute Memoranda of Understanding, Letter of Working Agreement, or other formal agreements with preventive and primary health care, mental health, substance abuse, domestic violence, developmental disability, homeless, early learning providers, and Limited English Proficiency service providers in the community, regional perinatal care services and Early Intervention access points.
- 3.1b Local home visiting programs will execute Memoranda of Understanding or other formal agreements with other social service providers in the community.

**Goal 4: Home visiting programs improve the lives of participating families in the areas described by the national benchmarks**

- 4.1a. Home visiting programs improve the health of women by helping them gain health insurance coverage, by linking them to preconceptional, prenatal and primary care services, through screening for perinatal mood disorders, substance abuse, developmental delay and other conditions, and by linking women to community

- services to address these conditions. (This is the portion of Benchmark 1 that applies to women of child-bearing age.)
- 4.1b. Home visiting programs improve the health of children through the promotion of breastfeeding, by helping them gain health insurance coverage and by linking them to preventive and primary care services. (This is the portion of Benchmark 1 that applies to children.)
  - 4.2 The rate of childhood injury, abuse and neglect among participating families and reduction of emergency department visits will decrease over time. (This is part of Benchmark 2.)
  - 4.3a Parents in participating families will improve their knowledge of child development, improve their parenting skills and avoid the use of harsh discipline in order to promote their children’s cognitive, emotional and social development. (This is part of Benchmark 2.)
  - 4.3b. Children in participating families will meet developmental milestones for cognitive, language, motor, social and emotional development; children who exhibit developmental delays will be linked to Early Intervention services. (This is part of Benchmark 3.)
  - 4.4 Participating families will be screened for the presence of intimate partner violence; affected partners are referred for services and develop a safety plan. (This is Benchmark 4.)
  - 4.5 Participating families will increase their educational attainment, employment and household income and obtain health insurance coverage. (This is Benchmark 5.)
  - 4.6a Participating families affected by any of Illinois’ six high risk conditions<sup>10</sup> are identified and linked to additional assessment and treatment services. (This is part of Benchmark 6.)
  - 4.6b Participating families are screened or assessed for their need of additional health or social services and are linked to available service providers. (This is part of Benchmark 6.)

*Home Visiting is Part of a Comprehensive System.*

Home visitors provide support and bring knowledge of child development and community services to families who may be isolated by service barriers (e.g., transportation or language) or who may be affected by circumstances that interfere with the development of a healthy bond with their young children (e.g., a perinatal mood disorder). Providing services in the home setting allows a more complete understanding of the family’s needs and circumstances. Home is the child’s natural and most comfortable environment.

Illinois’ goals and objectives were developed to incorporate the role of home visiting programs in a comprehensive system. For this system to be effective we plan to create a structure to connect home visiting professionals and medical homes for the purpose of enhanced care coordination.

The American Academy of Pediatrics (AAP), in its policy statement “The Role of Preschool Home Visiting Programs in Improving Health and Developmental Outcomes” (February 2009), recommends that pediatricians should become aware of and participate in development of home-visiting programs in their communities. It also states that there is ample reason to believe that the synergy of home visitors working with pediatric clinicians could have positive effects on child health and development, and calls for free-flowing communication between home visitors and pediatricians Goal 1 and objectives 1.2 and 1.3 have been developed for this aspect of the project.

Other AAP clinical policy further strengthens the need for medical homes to link with home visiting and related community services, citing the relationship to developmental screening and referral (now recommended) and their benefit in terms of school readiness (benchmark 3). Connection with a home visitor gives the physician a view into

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<sup>10</sup> Maternal perinatal mood disorders, substance abuse, intimate partner violence, parental developmental delay, homelessness and limited English proficiency.

the family's home life and can be critical to his or her ability to provide care. The home visitor can share information to both reinforce anticipatory guidance and help shape care plans and recommendations; such information might cover environmental and safety risks in the home, availability of positive supports (books, safe play spaces), and potential domestic violence (benchmark 4), abuse, or substance use. Objective 4.1a and 4.4 have been developed for this aspect of the project.

In addition to strengthening the link between medical homes and home visiting as part of the implementation of home visiting programs at the community level, the Strong Foundations Partnership will continue its efforts to develop the state and local infrastructure required to support the effective operation of home visiting programs. One of the system enhancements will be the development and testing of a universal screening and coordinated intake system in the MIECHVP target areas based on the New Jersey model

The Partnership will draw on the state's experience with development and implementation of the All Our Kids (AOK) Early Childhood Networks and other collaborative initiatives to strengthen the early childhood service delivery system in the MIECHVP target areas. This component is described in Section 3. The community systems workgroup of the Early Learning Council continues to develop technical assistance tools that also aid in this effort. Further, the staffing, information technology and partnerships that will be required at the state level are described in Sections 4 and 6. As part of an integrated approach supporting home visiting the state provides training of home visitors, monitoring local program operations and continuously improving their quality through the analysis of program data and the provision of additional technical assistance and training. This integrated approach is intended to support home visiting programs of all types, whether they are established, evidence-based models or innovative, promising approaches. In support of this effort, the Executive Committee plans for the EBHV and MIECHVP grants synergistically. Goal 1 and objectives 1.1 through 1.4 have been developed for this aspect of the project.

Goal 2 and objectives 2.1 through 2.6 have been proposed to assure that each home visiting program will operate with fidelity to the guidelines established by its model developer and use management information to continuously improve the quality of service delivery.

Home visitors bring information and help new parents promote their children's development and reduce their risk of injury or maltreatment. They also link families to other community services, such as preventive and primary health care, mental health and substance abuse treatment services, domestic violence shelters and services, child care, transportation, education, employment, food, shelter, income assistance, and many others. The proposed access to the DCFS provider database will help facilitate appropriate and timely referrals. The connection of ancillary services through this database will help to build a stronger, more integrated service community. Goal 3 and objectives 3.1a and 3.1b and Goal 4 and objectives 4.1 through 4.6 have been proposed to address the improvement of parents' knowledge of child development and to address the importance of linkages to community services in order to improve the health of participating families and achieve national benchmarks.

A logic model for Illinois' Maternal, Infant and Early Childhood Home Visiting Program is presented in Attachment 1. The model summarizes the four basic components of Illinois' strategy: universal screening and coordinated intake; operating home visiting programs with fidelity to national models; connecting home visiting programs to the providers of services required by Illinois' high-risk target populations, including medical homes; and developing an effective and coherent early childhood service delivery system.

### **Section 3: Selection of Proposed Home Visiting Models and Explanation of How the Models Meet the Needs of the Targeted Communities**

#### **Selected Models and Adaptations**

The Illinois Home Visiting Task Force has endorsed the following evidence-based models for implementation through the MIECHVP: Early Head Start, Healthy Families America, Healthy Steps for Young Children, Nurse-Family Partnership, and Parents as Teachers. All but one of these home visiting models are in widespread use in Illinois.

## **Experience with the Selected Models**

Early Head Start: There are 30 Early Head Start grantees in Illinois. These grantees serve 61 of Illinois' 102 counties and 42 of Chicago's 77 community areas. Altogether, the program can support 4,735 children. The total federal investment in Early Head Start is \$50.5 million in Illinois; the new ARRA funds more than doubled the federal government's investment. Of the 30 Early Head Start programs in Illinois, 28 programs currently operate home visitation services as one of their program service delivery options; 43 percent of the children in Early Head Start in Illinois are served through programs that offer the home-based option. Early Head Start home visiting programs use a variety of curricula including the Parents as Teachers' "Born To Learn" curriculum and can obtain training in its use through the Illinois Birth To Three Institute.

Early Head Start programs obtain training through the Early Head Start National Resource Center, the 20 national Centers of Excellence, the Region V Training and Technical Assistance System and from various local resources. The Region V Training and Technical Assistance system includes intensive on-site management systems consultation for new programs as well as programs that are having difficulty meeting the national performance standards. In addition, the Region V Training and Technical Assistance system provides ongoing technical assistance to Head Start and Early Head Start grantees in the area of early childhood development through state-based teams of Early Childhood Education Specialists. Each state team includes an Infant Toddler Specialist with expertise and training specifically in working with the birth to three population.

The federal Region V Office of Head Start is responsible for program monitoring and quality assurance. Head Start programs submit monthly enrollment reports, annual program performance and demographic data reports, semiannual progress reports, and annual continuation application and an annual self-study. In addition, based on the information gathered from various data sources, the Regional Office of Head Start conducts annual Risk Management meetings with each Head Start grantee to identify potential areas of programmatic and fiscal risk and determined action steps to mitigate these risk factors. Nationally, the Office of Head Start conducts a comprehensive, on-site, program and fiscal compliance reviews of each grantee, every three years. Based on the results of these reviews, Head Start programs may receive one or more additional follow-up on-site monitoring reviews to ensure that corrective actions have been fully implemented. For those communities implementing Early Head Start as a program model for the Strong Foundations Partnership, the Executive Committee will work with the Office of Head Start to develop a memorandum of understanding to share monitoring information and coordinate monitoring activities.

A regional staff member from the Office of Head Start and the State Head Start Collaboration Office have been active participants in the Home Visiting Task Force. The Illinois Head Start Association is an important source of training, technical assistance and advocacy at the state level.

Healthy Families America: Illinois currently supports 47 Healthy Families America (known as Healthy Families Illinois or HFI) programs across the state. The IDHS funds 37 of these programs directly and nine programs indirectly through the Ounce of Prevention Fund as a part of the Parents Too Soon program. The Illinois State Board of Education funds one Healthy Families Illinois program. The first Healthy Families Illinois programs were funded by IDHS in 1997.

The IDHS has provided funding since 1997 to train Healthy Families Illinois program staff through the Ounce of Prevention Fund's Illinois Birth To Three Institute. Core, advanced, periodic and special topic training programs are provided for Family Assessment Workers, Family Support Workers, program supervisors and program managers.

IDHS Division of Community Health and Prevention staff are responsible for program monitoring and quality assurance. Programs are reviewed through regular site visits using a protocol developed from Healthy Families America standards; the current version is based on the "Healthy Families America Self-Assessment Tool 2008-2010". (This review does not replace of the formal peer review accreditation process. However, IDHS does provide supplemental funds to offset the cost of accreditation when sites are ready to undertake the process. Thirty-three Healthy Families Illinois programs are currently accredited by Healthy Families America.)

The IDHS also supports local Healthy Families Illinois programs through the use of the Cornerstone management information system. This system collects data on participant characteristics and program activities (e.g., number and frequency of home visits), referrals for services and, through linking with existing data systems, data on health service utilization and maternal and infant health outcomes. The Ounce of Prevention Fund provides “OunceNet” software for use by all of its Parents Too Soon programs, regardless of home visiting model.

Healthy Steps for Young Children: Illinois has five Healthy Steps for Young Children program sites, all of which are located in the Chicago area. Two of them are based in pediatric residency programs in children’s hospitals, one is based in a family practice residency program, one is based in the department of pediatrics at a university children’s hospital and one is based in a Community Health Center. The staffs of these organizations have completed Healthy Steps training and have employed Healthy Steps Specialists who provide home visits. Two of the sites are part of the original national demonstration project from 1997 and the others were added in 2001.

Advocate Healthcare’s Healthy Steps program also works closely with the Illinois Chapter of the American Academy of Pediatrics and the Illinois Department of Healthcare and Family Services to implement the Enhancing Developmentally-Oriented Primary Care (EDOPC). Also based on Bright Futures, the EDOPC project provides training for Federally-Qualified Health Centers and Community Health Centers to support child development. The EDOPC project does not include the full array of topics required for recognition as a Healthy Steps program and does not include home visiting. However, clinics that have completed EDOPC training could easily become Healthy Steps projects with additional training and staff.

Training and technical assistance are available from Advocate Health Care’s Healthy Steps Program. The basic, four-day Healthy Steps training is conducted annually and technical assistance is provided upon request by program staff. Continuing education is provided through on-site training, teleconferences, the EDOPC project’s web site ([www.EDOPC.net](http://www.EDOPC.net) now has five topics available), and the Healthy Steps multi-media training kit. The EDOPC project provides monthly technical assistance calls in which Healthy Steps sites participate. Healthy Steps program staff also assist local sites in recruiting Healthy Steps Specialists and in linking participating clinics to local community resources.

The Strong Foundations Partnership is implementing Healthy Steps as a secondary model of home visiting. Communities that are interested in using this approach must also implement one of the other home visiting models and coordinate the activities and services of both programs. Healthy Steps was designated as a secondary strategy because of the limited number of home visits required during the first three years of life.

Nurse-Family Partnership: Illinois has five Nurse Family Partnership programs located in: Chicago (south side) Kane County and DuPage County, west of Chicago; Lake County, north of Chicago and Mount Vernon, (in the southern part of the state).

The Nurse Family Partnership programs obtain training from, and as prescribed by, the Nurse Family Partnership National Service Office (NSO) in Denver, Colorado. Programs receive monthly telephone follow-up (for clinical nursing support, ongoing education for supervisor and staff, the use of ETO data to inform and strengthen the services) and an annual site visit by a nurse consultant from the NSO. Program data, collected through the NSO’s Efforts to Outcomes™ information system, are used to continuously improve the quality of program operations. A full quality assurance review is conducted on-site every three years by the National Service Office (NSO) as a part of renewing the site’s contract.. The Nurse Family Partnership Program Developer for the Midwest Region has been an active participant in the Home Visiting Task Force since its inception.

Parents as Teachers: The rapid expansion of Parents as Teachers (PAT) in Illinois began in 2006 when the ISBE redirected funds for the “zero to three set-aside” within the state-funded Early Childhood Block Grant. Recipients of these funds were required to support evidence-based models. HFA, NFP and PAT were among the approved models. The ISBE currently funds 104 Parents as Teachers programs. Nine more Parents as Teachers programs are funded by IDHS and operate through the Ounce of Prevention Fund as a part of the Parents Too Soon program. To the best of our knowledge, all 113 of Illinois’ Parents as Teachers programs are currently affiliated with the Parents as Teachers national office. None of them has yet achieved Commendation.

Illinois has a well established state infrastructure for the support of Parents as Teachers. This includes the Illinois Birth to Three Institute, which is responsible for training all staff of Parents as Teachers programs. The Institute conducts basic and continuing training for parent educators, program supervisors and program managers and provides technical assistance to assure quality statewide. The Institute only uses trainers who have been certified by the Parents as Teachers National Office to conduct this training and uses curricula that have been approved by PAT. ISBE selected the Ounce of Prevention Fund to perform the functions of the PAT State Office beginning January 1, 2008.

The State Office provides technical assistance to PAT programs. This begins with the review of the program plan submitted by each site. Once a site's program plan has been approved and site personnel have completed Foundational and Model Implementation training, technical assistance staff from the State Office schedule a site visit to occur between three and six months after the completion of training. Staff complete a program survey during this site visit; this information is used to formulate a technical assistance plan for the site. Additional assistance is provided by telephone and electronic mail. The State Office also performs an annual program review which is focused on fidelity to PAT's Essential Requirements. After three years of operation, PAT programs are eligible to apply for Commendation, the formal recognition of a site's conformity with the Essential Requirements. Achieving Commendation requires the completion of a self-study, video recording of home visits and parent groups and a site visit by a review team. PAT programs supported by MIECHVP funds will be expected to apply for Commendation. The State Office will assist sites in preparing for Commendation.

Of the 104 ISBE-funded PAT programs, 53 use the national Visit Tracker© software developed by DataKeeper Technologies.

While there is no state-level collaborative body for PAT that is comparable to the Healthy Families Working Group, state leaders from ISBE have been active members of the Strong Foundations Partnership. Staff from many local PAT programs serve on Home Visiting Task Force committees.

**Ensuring Implementation with Fidelity:** Each of the models selected for replication in Illinois is based on a set of criteria articulated by the model developer. For Early Head Start, they are contained in federal program requirements. For Healthy Families America, they are contained in that organization's "Critical Elements for Successful Programs." For Healthy Steps, the minimum requirements are presented in the "Healthy Steps for Young Children Policy on the Use of the Healthy Steps Name and Logo." For Nurse Family Partnership, they are contained in the "Model Elements." For Parents as Teachers, program criteria are found in the "Essential Requirements." Illinois' approach to quality assurance is to ensure that local program operations conform to these standards. This assurance is obtained through the collection and analysis of both quantitative and qualitative information about program performance.

The first step in the process is to examine a candidate provider's plan for implementing the model. For example, prior Requests for Proposals (RFP) issued by IDHS for Healthy Families Illinois have asked respondents to describe how each of the Critical Elements for Successful Programs will be implemented in the program they are proposing. Proposal reviewers received training on the Critical Elements; in order to receive consideration for funding, applicants were required to demonstrate to reviewers that they understood the model's standards and to present a feasible plan for implementing them. The same approach will be used in reviewing the program plans that will be submitted by providers in the Target Areas. (More information on the local program plan is provided in Section 4.)

The second step in quality assurance is training. New staff in HFI or PAT programs receive training through the Illinois Birth To Three Institute. New staff in an NFP program receive initial training, as well as ongoing education and clinical support, through NFP's National Service Office. Staff in Healthy Steps programs may receive training from the Advocate Health Care in Chicago.

The third step is implementation support. This work begins through the establishment of a working relationship between the community provider and one of the Division's Community Support Services Consultants. The consultant will orient the provider's staff to the Division, assist the agency in developing relationships with other organizations in the community and monitor the agency's progress in program implementation through regular contact.

The fourth step in quality assurance is the definition, collection, analysis and application of information on program operations. Each model's standards serve as the basis for identifying the data that are required to measure the extent to which a program has been implemented and operated with fidelity. Both quantitative and qualitative information are required to measure fidelity. The quantitative data has been operationally defined in the model-specific information systems developed to support these programs. (More information on the information systems that Illinois will use for continuous quality improvement may be found in Section 4.) These data will be summarized and used by local program staff, state program managers, Community Support Service Consultants, trainers and others to describe the current state of program operations and compare performance to each model's standards. The application of data to improve performance completes the process of continuous quality improvement and quality assurance. The information system that IDHS now uses to support Healthy Families Illinois programs, Cornerstone, produces management reports for Healthy Families Illinois that can be used routinely to monitor and improve program performance.

Qualitative data for quality assurance are collected through on-site examination of program records. These data are especially valuable in examining the delivery of the program's curriculum and other aspects of the content of the home visit itself. These data are also useful in examining the extent to which participating families' service needs have been addressed. For the Division of Community Health and Prevention, this process is referred to as Quality Review and Support. It is conducted less frequently (from annually to triennially), the results are reported to local agencies and division administration more formally (through a written report) and the report may require local agencies to change certain aspects of program operation (to conform with state or federal statute or regulation) or recommend that changes be made to improve program performance. If changes are required in response to a program review, completion of the corrective action is also formally documented. These activities will be closely coordinated with the technical assistance and consultation provided by the PAT State Office and NFP's National Service Office.

The IDHS and the ISBE encourage (but do not require) local HFI and PAT programs to formally affiliate with the national organizations that support these models and to complete the model developer's independent quality assurance process. IDHS provides financial support for a limited number of HFI programs to complete the accreditation process each year. Currently, 33 HFI programs are accredited by Healthy Families America. All 110 PAT programs are affiliated with the Parents as Teachers national organization, but none of them has achieved commendation. NFP does not have an analogous process; the NFP's NSO executes a contract with each local agency that is implementing the model. An on-site quality assurance review is conducted triennially prior to contract renewal. The federal Office of Head Start requires monthly, semiannual and annual reports and an annual continuation application from local implementing agencies. Performance problems may be addressed during the preparation of the annual continuation application. The Office of Head Start also conducts an on-site program review every three years. Healthy Steps for Young Children has specified requirements for using the Healthy Steps name and logo; no formal periodic review of program operations is conducted by the model developer.

Four challenges to maintaining fidelity in the operation of home visiting programs can be anticipated. First, the availability and quality of program training must be maintained. Illinois will continue to allocate resources to training and ensure that training is regularly available and accessible to programs across the state. Trainers must also continue to meet national standards. Second, the state funding agencies (IDHS, ISBE and the Ounce of Prevention Fund) must increase their commitment to collecting, analyzing and applying program data for continuous quality improvement, quality assurance and outcome evaluation. This includes a sustained commitment to the information systems used for this purposes, as well as the staff required to analyze and interpret the data and assist local organizations in applying the information to improve program performance. Third, local home visiting programs must recruit and retain a qualified workforce, provide program staff with adequate training and supervision and ensure that their staff is not overburdened with excessive caseloads. Finally, state level leadership must maintain its commitment to operating local programs with fidelity to their national models. The state of Illinois has demonstrated its ability over the last 15 years to maintain the availability and quality of training, data collection and analysis and leadership. Therefore, most of these risks and challenges are minimal. However, the state's economic downturn has resulted in delayed payments to local service providers; this, in turn, has caused layoffs of qualified and experienced staff at the local level and the closure of HFI or PAT programs in some communities.



## **Matching Models to Community Needs**

Chicago South Side. Expanded home visiting programs in Englewood, West Englewood and Greater Grand Crossing would meet a critical need for early intervention for the community's highest-risk families. The Planning Team has selected the Nurse Family Partnership program, Healthy Families Illinois, and Parents as Teachers based on the needs and strengths of the target communities. The selection of the Nurse Family Partnership program is based on the extremely poor maternal and child health outcomes in the community and the strong medical providers (ACCESS, Mercy Family Health Center, and the Chicago Department of Public Health's Englewood Clinic) which are community assets and have the relationships, infrastructure, and experience required to implement NFP. The planning team selected HFI based on the very high rates of child abuse and neglect in the community and the fact that two members of the planning team, Family Focus Englewood and Henry Booth House, implement accredited HFI programs with a broad reach in the target communities. The selection of Parents as Teachers is based on commitment to supporting parents in the community with limited resources and the need to ensure that children develop appropriately to succeed in school. Children's Home + Aid and Family Focus Englewood currently offer PAT in Englewood.

City of Elgin. The Elgin early childhood coalition recommends that existing Parents as Teachers, Early Head Start, and Nurse Family Partnership Home Visitation Programs be expanded and that the Healthy Family Illinois which currently serves Aurora in the southern part of the county be expanded to serve families in Elgin. The Home Visiting Council has enjoyed a long and effective partnership in meeting the diverse needs of families because a variety of Home Visitation models were available in the community to match these needs. This "big tent" approach to evidence-based home visitation is highly visible in Illinois as a means of meeting the needs for home visitation among all the at-risk subpopulations.

Macon County. The various providers in the Macon County Consortium are committed to building a system of collaborative support, screening every family, identifying needs, and delivering appropriate services to at-risk children in Macon County. Macon County service providers currently offer three of the four primary models of home visitation: Early Head Start – Home Based; Healthy Families Illinois; and Parents As Teachers.

City of Rockford. The community of Rockford, Illinois reports being in position to begin implementation of the MIECHVP immediately. Due to ongoing community collaboration and with numerous systems in place Rockford is ready to immediately expand home visiting services.. Using both the public health model and a community development model Rockford will 1) identify needs, 2) determine solutions and 3) engage the community as Rockford promotes optimal pregnancy outcomes and healthy early childhood development. The MIECHVP initiative will focus on expansion of the Parents as Teachers program, Early Head Start and Healthy Families Illinois by doubling the current capacity of each program.

Cicero Township. With the majority of children under five lacking early childhood services, and because of the mix of teen parents, single mothers, and married parents living in Cicero, it is necessary to choose a home visiting model that is flexible enough to work with parents at different ages and levels of parenting knowledge and skill. The requisite to enroll before the 28th week of pregnancy for Nurse Family Partnership, the intensity of weekly service involved in Early Head Start and HFI make them less likely to serve the greatest number of families and children in need. Therefore, Cicero's collaborative will adopt the PAT home visiting model

Vermillion County. To preserve and build on Vermillion County's community collaborative efforts and assertive outreach to rural communities that are currently underserved, the utilization of the Parents as Teachers (PAT) model allows for referrals, data collection and services to flow seamlessly. PAT has flexibility to enroll a child in services prenatally until four years of age. This expanded intake eligibility is important to serve Vermillion County's identified underserved populations.

The expansions can be summarized as follows:

Models to be Expanded in Illinois' MIECHVP Target Areas					
Community	Proposed Expansion				Target Population
	Early Head Start	Healthy Families Illinois	Nurse Family Partnership	Parents as Teachers	
Chicago South	Yes	Yes	Yes	Yes	Pregnant women, teen mothers, first-time mothers, children who screen at high risk of abuse or neglect.
Elgin	Yes	Yes	Yes	New program to begin operation in June 2011	High risk by poverty or by definition
Macon County	Yes	Yes	Yes	No	Pregnant women, teen mothers, rural families and children currently on waiting list
Cicero	No	No	No	Yes	Teen mothers
Rockford	Yes	Yes	No	Yes	Teen mothers at risk of low birth weight
Vermillion County	No	No	No	Yes	Pregnant women, teen mothers, rural families and children currently on waiting list

**Innovations and Promising Approaches:** No funding for innovative or promising approaches to home visiting is included at this time. Financial support of these approaches will be considered as additional federal funds become available.

**Additional Components of Illinois' MIECHVP:** Two additional components will be developed and implemented as a part of Illinois' MIECHVP. First, *the selected communities will develop and test a system for universal screening and coordinated intake for all early childhood services*. The purpose of such a system is to ensure that every family in a community who might benefit from the array of available services and supports has the opportunity to take advantage of them.

The development and testing of this system will require some time. The system must include entry points for pregnant women and families with young children of all ages (rather than limiting the system to newborns). Some of these access points include medical homes for women and children designated by Illinois' All Kids program, the Part C Early Intervention system (which will also be receiving referrals from home visiting programs), Illinois' regionalized perinatal care system and others. On the other hand, several early childhood programs, such as the Part C Early Intervention and Child Care programs, have regional intake or information and referral coordination systems in operation. This new approach will have to successfully interface with these existing systems.

The Task Force will begin work on the design of this component during the next year. The coordinated intake system developed by the New Jersey Department of Children and Families and Prevent Child Abuse New Jersey for that state's Supporting Evidence-Based Home Visiting Programs to Prevent Child Maltreatment grant provides a starting point for development. Representatives from the New Jersey program participated in a conference call with the full Home Visiting Task Force on March 18, 2011 to present the model they have developed. The essential components include:

- A strategy for prenatal and post-partum engagement of all families with newborns in the target area.
- A procedure for identifying the family's service needs and linking them to medical homes and other appropriate community providers.
- Capacity for developing collaborative relationships with agencies that are serving pregnant women or newborns on the one hand and providing home visiting and ancillary services on the other hand.
- Connection to the data system for continuous quality improvement and outcome evaluation;

- Connection to the broader early childhood service delivery system in the community.

The second addition to Illinois' MIECHVP is the ***development and support of strong local collaborations among parents and early childhood service providers***. The A number of initiatives in Illinois have a community building aspect, including SAC, EBHV, the BUILD Initiative, the State Early Childhood Comprehensive Systems grant (SECCS), Project LAUNCH, and the Strengthening Families Initiative. A portion of the state's SAC grant funds will be used for a consulting project, informed by the work of ELC Community Systems Development Workgroup., to supports the Partnership in carrying forward the broader state goal for birth to five services of raising awareness about the importance of community collaborations as well as provide technical assistance to build strong local community partnerships in Illinois' communities.

Through use of the existing capacity building structures that are in place and coordinated by the Community Systems Development Workgroup, the Partnership will be able to maximize upon efforts toward collaboration and best meet the needs of local communities. One model that serves as an example of such local work are the All Our Kids (AOK) Early Childhood Networks, a local system-building effort to provide a comprehensive and coordinated system of care for families with young children. Through the Networks, early childhood providers coordinate services, reduce duplication and fill gaps in services, and maximize resources. AOK works to make families more aware of available services and to facilitate their access to those services. The networks were developed to implement public health's ten essential services<sup>11</sup> with a focus on early childhood system development and bring parents and community health human service providers together to build a more effective system. Currently, AOK Networks are operating in 11 local counties/community areas geographically distributed throughout Illinois. Nine of the networks are funded by IDHS and two are funded by ISBE.

#### **Section 4: Implementation Plan for Proposed State Home Visitation Program**

This Section presents Illinois' plan for implementing and monitoring the MIECHVP in Illinois. The implementation plan is divided into state-level and local-level activities. This section concludes with the plan for on-going monitoring of local projects.

#### **Implementation Plan**

##### ***State Level***

**Policy and Standards.** Illinois has a strong record of working collaboratively at the state and /or local levels on early childhood program design and delivery. Moreover, for much of the past decade, Illinois has enjoyed a political climate supportive of the development of the early childhood system.

This is evidenced, for example, in the creation in state statute of the Early Learning Council (ELC) in 2003. The ELC was established to guide the development of a statewide early childhood education and care system to ensure that both young children at risk for school failure and their families experience high-quality programming and services necessary for healthy child development. ELC would also work on the subsequent passage of legislation to create the Preschool for All program in 2006. In fall 2009, at the recommendation of the ELC, the governor created the Office of Early Childhood Development (OECDD) within the Governor's Office to solidify Illinois's efforts to establish a comprehensive, statewide early childhood system

The Home Visiting Task Force, a standing committee of Illinois' Early Learning Council, brings together state policy makers, advocates, families, academics and service providers to advance the development of home visiting in Illinois. The Home Visiting Task Force also serves as the strategic decision making and interagency coordination body for both Strong Foundations (the Supporting Evidence-Based Home Visiting Programs for the Prevention of Child Maltreatment grant) and the Strong Foundations Partnership (the MIECHVP grant). The full Task Force meets three or four times a year.

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<sup>11</sup> U.S. Centers for Disease Control and Prevention. National Public Health Performance Standards Program: ten essential public health services. [www.cdc.gov/nphsp/essentialServices.html](http://www.cdc.gov/nphsp/essentialServices.html).

The Project Director for both Strong Foundations and The Strong Foundations Partnership is employed by the Governor's Office of Early Childhood Development. This ensures that implementation of both projects has the highest level of support within the executive branch.

The Illinois Department of Human Services serves as the lead agency for implementing the MIECHVP in Illinois. The Department's Division of Community Health and Prevention is also responsible for the Maternal and Child Health Services Block Grant and the SAC grant. The Title V Director serves as the primary liaison with the federal Maternal and Child Health Bureau and the Administration for Children and Families on implementation of MIECHVP.

The Illinois State Board of Education's Division of Early Childhood administers the state-funded Early Childhood Block Grant. Approximately fourteen percent of the funds appropriated for the block grant are "set aside" to serve children between birth and three years of age. It is from these funds that ISBE supports more than 100 Parents as Teachers programs across the state.

The IDHS and ISBE are committed to supporting the replication of home visiting programs with fidelity to the standards established by the model developers. As described elsewhere in this Implementation Plan, both agencies have incorporated these standards into requests for proposals, training programs for local program staff, monitoring procedures, data collection systems and program evaluations.

**Partner Organizations.** The following organizations are represented on the Home Visiting Task Force:

State and federal agencies: Administration for Children and Families, Region V, Governor's Office of Early Childhood Development, Illinois Children's Mental Health Partnership, Illinois Department of Children and Family Services, Illinois Department of Healthcare and Family Services, Illinois Department of Human Services, Illinois State Board of Education, University of Illinois at Chicago Division of Specialized Care for Children

Parents: B. Cervantes, Parents as Teachers, K. Magnuson, Parents as Teachers, K. Gillihan, Healthy Families Illinois, R. Schubert, Healthy Families Illinois

Advocacy organizations: Fight Crime, Invest in Kids, Illinois Action for Children, The Kids Public Education and Policy Project, Prevent Child Abuse Illinois, Voices for Illinois Children,

Academia: Chapin Hall at the University of Chicago, Erikson Institute, Northern Illinois University, University of Illinois at Chicago, Institute for Juvenile Research, University of Illinois at Urbana-Champaign, Early Childhood and Parenting Collaborative

Private Funders: The Ounce of Prevention Fund, The United Way of Metropolitan Chicago, McCormick Foundation, Irving Harris Foundation

Service Providers: Adolescent Health Center, Healthy Families Shawnee Program, Aunt Martha's Youth Service, Center, Baby TALK, Carole Robertson Center for Learning, Chicago Department of Family Support Services, Chicago Public Schools, Child Abuse Council, Quad Cities, Children's Home and Aid, Children's Home Association of Illinois, Good Beginnings, Chinese American Service League, Community Counseling Centers of Chicago, CPS Community Partnership Program, Dupage County Health Department, Easter Seals Children's Development Center, Easter Seals, Joliet Region, El Valor, Family Focus, Family Focus Englewood, Gads Hill Center, Health Connect One, Healthy Families (VNA of Fox Valley), Heartland Alliance, HIPPY, Infant Welfare Society of Evanston, Kane County Health Department, Lake County Health Department and Community Health Center, LaVoz Latina, Metropolitan Family Services, New Moms, Inc., Parenthesis Parent - Child Center, Positive Parenting DuPage, Southern Region Early Childhood Programs, Carbondale, Stephenson County Health Department, Teen Parent Connection, Teen Parent Program at Chicago Child Care Society, Women's Treatment Center, Chicago

**Working with National Model Developers.** The IDHS, the ISBE and the Ounce of Prevention Fund have long-standing relationships with Prevent Child Abuse America, Healthy Families America and the Parents as Teachers National Offices. The faculty of the Illinois Birth To Three Institute has been certified by at least one of these

national program offices as trainers in the Healthy Families America or Parents as Teachers models. The Midwest Program Developer for Nurse-Family Partnership has been actively involved in both Strong Foundations and the Strong Foundations Partnership and, along with the Nurse-Consultant from the NSO, is prepared to provide technical assistance and clinical support to new or expanded Nurse-Family Partnership programs in the MIECHVP target areas. Similarly, Advocate Health Care, the lead organization for Healthy Steps in Illinois, is represented on the Task Force and is prepared to assist family practice or pediatric clinics to implement the full Healthy Steps model. Finally, the Region V Office of Head Start is represented on the Task Force’s Executive Committee and is available to provide technical assistance to Early Head Start programs.

**Training (Obtaining Curricula).** The Ounce of Prevention Fund Training Institute’s schedule for April, May and June 2011 may be used to illustrate the volume and variety of training available to home visiting and related early childhood programs. The topics to be presented during those three months are listed below with regard to specific program models. The training schedule is available on line at <http://www.opftrainingcenter.org> and <http://pi.opftrainingcenter.org>. Illinois has a well-established mechanism to provide initial and ongoing training for many evidence based program models, including HFI, PAT, NFP, Healthy Steps, and EHS. Initial Training for HFI and PAT: Healthy Families America Core Training: Family Assessment Workers, Healthy Families America Core Training: Family Support Workers, Parents as Teachers Foundational and Model Implementation Training, Ages and Stages Questionnaire-3, Introduction to Mandated Reporting Online, Functional Hearing and Vision Training

Table 4 Summary of the Data Collection Strategy for Constructs and Benchmarks.					
Benchmark	Construct	Self-Report	Standardized Measure	State Administrative Records	Program Records/Staff Observations
Maternal and newborn health	Prenatal care (Kotelchuck Index)	X		Vital Records	
	Prenatal ATOD use	X	DAST	WIC	
	Use of birth control	X			
	Inter-pregnancy interval	X		Vital Records	
	Maternal depression		Edinburgh		
	Breastfeeding (6 mo. Duration)	X		WIC	
	Well-child care	X		All Kids data	
	Maternal health insurance	X		Medicaid data	
Child injury and CAN	Child health insurance	X		All Kids data	
	ER visits mother	X		Medicaid data	
	ER visits child	X		All Kids data	
	Training on key prevention concepts				Case records
	Incidence of child injury	X		Medicaid data	
	Reports of suspected maltreatment			DCFS	
	Confirmed reports of maltreatment			DCFS	
Improved School Readiness	First-time confirmed maltreatment			DCFS	
	Parenting support for learning/parent child relationship		PICCOLO		Home visitor observation
	Knowledge of child development		KIDI		
	Negative parenting style		CTS-PC		
	Parent emotional well-being		PSI		
	Child development		ASQ3		
	Child approach to learning/emotional well-being		ASQ:SE		
Domestic Violence	Child height/weight			WIC	
	Participant screened for domestic violence				Case records
	(if needed) access to DV services				Case records
Family Economic Self-Sufficiency	(if needed) development of safety plan	X			
	Household income (all sources)	X			
	Employment status (hours worked)	X			
	Educational level	X			
	Enrollment in continuing education/training	X			
Coordination of service referrals	Health insurance status	X		Medicaid, All Kids	
	Assessment for service needs				Case records
	Referrals for needed services				Case records
	Completed referrals				Case records

Several steps will be taken to safeguard the privacy of program participants and protect the confidential nature of the information provided to IDHS for analysis. First, IDHS will require that state and local staff that have access to the data sign an agreement acknowledging the confidential nature of the information and the disciplinary actions that can be taken for unauthorized disclosure. Second, IDHS will require that the software package use several levels of password protection to limit the amount of information that state and local users can access. Third, participants will be asked to sign a statement of informed consent for the collection of project-related data and release of information provided to other sources (e.g., other state agencies). Fourth, the data collection contractor will ask participating families to sign a statement of informed consent at each data collection interview. Both consent forms will be translated into Spanish. Fifth, state staff will not publish data about individual participants, nor report on rates with fewer than 10 observations in the numerator in order to avoid unintended identification of project participants. Sixth, all of the consent forms, the analysis plan and the confidentiality procedures will be submitted to an Institutional Review Board for review and approval before use.

The IDHS has contacted and intends to work with the Western Institutional Review Board, a private and independent institutional review board located in Olympia, Washington. According to its web site, “Western Institutional Review Board (WIRB) is duly constituted, has written procedures for initial and continuing review of clinical trials; prepares written minutes of convened meetings, and retains records pertaining to the review and approval process; all in compliance with requirements of FDA regulations 21 CFR Parts 50 and 56, HHS regulations 45 CFR 46, and International Conference on Harmonization (ICH) E6, Good Clinical Practice (GCP), as applicable. WIRB is registered with OHRP/FDA; our IRB registration number is IRB00000533, parent organization number is IORG0000432.”<sup>12</sup> IDHS has worked with this organization on several projects. Funds for this purpose are identified in the project’s budget.

IDHS will maintain the quality of the data by selecting a software package which includes within-field and cross-field edit requirements to prevent the collection of spurious data. Data quality will be assured by hiring qualified data management personnel at the state level. IDHS proposes to hire a business analyst to assist in the selection of the most appropriate software package, one that meets the federal reporting requirements and more important the requirements of the home visiting providers. Several barriers and challenges to the implementation of this data collection plan can be anticipated; some can be avoided. First, acquisition of the data collection software may take longer than expected. However, the project enjoys the support of senior-level management within IDHS as well as the Governor’s Office of Early Childhood Development; this level of administrative support should expedite the selection process. Second, as noted in the tables for several constructs, data from Illinois’ vital records system may not be available for analysis for two years following the year in which the vital event occurred. This is due to staffing shortages at IDHS. To compensate for this, participants will be asked to self-report the information used to measure these constructs. Their self-report will be replaced with administrative data when it becomes available.

In summary, Illinois’ data collection and analysis plan meets the following federal requirements:

- Data will be collected to measure all of the constructs for all of the benchmarks;
- Data will be collected for eligible families who receive home visiting services that are supported by federal MIECHV Program funds;
- Standard measures will be collected across evidence-based home visiting models;
- Data will be collected from all participating families (rather than from a sample of participating families);
- Data will be extracted from available administrative data systems whenever possible; and

Data on demographic and socioeconomic characteristics will be collected from each participating individual. At a minimum, these characteristics will include age, sex, race, origin, language, education and income.

#### **Section 6: Plan for Administration of the State Home Visiting Program**

Policy leadership for the development of a statewide system of home visiting programs is provided by the Governor’s Office of Early Childhood Development, the IDHS and the mix of public and private partners serving on

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<sup>12</sup> [http://www.wirb.com/content/about\\_compliance.aspx](http://www.wirb.com/content/about_compliance.aspx)

the Early Learning Council and the Council's Home Visiting Task Force. Grants to support local home visiting programs will be overseen by the state agencies that fund them; grants of MIECHVP funds will be overseen by the Bureau of Child and Adolescent Health in the IDHS' Division of Community Health and Prevention.

This management plan meets statutory requirements. State and local program staff will be recruited and selected in accordance with established personnel policies. Training of the new MIECHVP program staff at the local level will be provided through providers certified by the national home visiting model developers. Program managers and supervisors will receive training on high-quality, reflective supervision. NFP' NSO will provide the education, training, ongoing education, and clinical support for NFP administrators, supervisors,

State staff will work closely with the model developers to ensure that local programs are designed, implemented and managed with fidelity. Home visiting programs will be integrated into community referral networks and monitoring operations to ensure fidelity with national standards. Illinois' plan for MIECHVP is consistent with the plans of the State Advisory Council on Early Care and Education and the State Early Childhood Comprehensive Systems initiative. This new federal initiative will be integrated with related state and federal initiatives to improve early childhood development.

**Lead Agency and Overall Management Plan.** The MIECHVP Project Director will report to the Director of the Governor's Office of Early Childhood Development. This reporting relationship has been established to support coordination of activities among the IDHS, the Illinois State Board of Education, the Illinois Department of Children and Family Services, the Illinois Department of Healthcare and Family Services, and the Illinois Department of Public Health. The Project Director for MIECHVP will also serve as the Project Director for the "Supporting Evidence-Based Home Visiting Programs to Prevent Child Maltreatment" grant from the federal Administration for Children and Families.

The IDHS will be the lead agency for implementation of the MIECHVP in Illinois. Responsibility for administration of grant funds and for monitoring local home visiting program implementation rests with the Bureau of Child and Adolescent Health of the Illinois Department of Human Services' Division of Community Health and Prevention. This bureau is also responsible for management of the Healthy Families Illinois and Parents Too Soon programs. The Associate Director for Reproductive and Early Childhood Services (Illinois' Title V Director) will serve as the primary contact with the federal Maternal and Child Health Bureau and ensure coordination of MIECHVP activities with other programs and services supported by the Maternal and Child Health Services Block Grant.

Two individuals will be hired contractually by the IDHS for this project. The Business Analyst will meet with stakeholders of the MIECHV program for the purposes of developing a system for universal screening and coordinated intake and selecting a reporting system that meets the requirements of community providers and federal funders. This position will report to the Section Manager, Unified Provider Health Systems, Office of Management Information Systems, Illinois Department of Human Services.

The MIECHVP Community Network Coordinator will work to build and sustain local home visiting programs funded through the MIECHV Program by providing system development support for communities identified as being at risk for poor health, parenting and educational outcomes. This position will report to the Chief of the Bureau of Child and Adolescent Health, which is under the purview of the Associate Director for Reproductive and Early Childhood Services.

This administrative structure ensures that the management of program grant funds is closely coordinated with the other home visiting programs that are part of Illinois' Maternal and Child Health program; ensures that MIECHVP is closely coordinated with the rest of Title V; ensures that the home visiting programs operated by IDHS will be coordinated with those operated by ISBE; and ensures that the home visiting programs will be coordinated with the publicly-funded ancillary services that many participating families will require.

**Collaborative Partners in the Public and Private Sectors.** The membership of Illinois' Home Visiting Task Force was presented in Section 4. The local agencies from each community that participated in the selection of models for their communities were presented in Section 1.

**Plan for Coordination Among Home Visiting Programs.** Illinois' plan for universal screening and coordinated intake was presented in Section 4 (see, "Identification and Recruitment of Participants").

**Current Evaluations.** No evaluations of local home visiting programs are currently underway.

**Job Descriptions for Key Personnel.** Please refer to Attachment 4 for job descriptions of the Title V Director, the Project Director, the Business Analyst and the Community Network Coordinator.

**Organization Chart.** Please refer to Attachment 3 for a copy of the MIECHVP Organization Chart.

### **Meeting The Requirements of Title V, Section 511**

Well-trained, Competent Staff. State staff will be hired according to the policies and procedures established by the Illinois Personnel Code (20 ILCS 415 et seq.). According to the Illinois Department of Central Management Services (IDCMS), which is responsible for the administration of the code, it "[I]s the law that provides the basis for the civil service merit system in Illinois. It embraces all positions of employment in the service of the state unless specifically excluded by legislation. It empowers the Director of Central Management Services to promulgate Rules and carry out this law, and creates the Civil Service Commission to monitor its proper administration and to conduct hearings.

"The Code consists of three jurisdictions: Jurisdiction A, Classification & Pay, which provides for a system of pay administration and position reporting and classification to assure that the work of employees is fairly compensated, consistent with the level and kind of job they perform; Jurisdiction B, Merit & Fitness, covering candidate testing and selection, certification, performance appraisal and discipline, and other merit practices for employees; Jurisdiction C, Conditions of Employment, which deals with such things as vacation, holidays, sick time, grievance plans, and other provisions that establish a body of uniform personnel practices across agencies.

"...The Personnel Code was written to provide broad administrative powers to the Director, to carry out a personnel program "based upon merit principles and scientific methods", and indeed the law survived with little change over the years, and has been able to embrace a number of significant changes in the human resources field without the need for a major overhaul." (IDCMS)

Positions that are subject to a collective bargaining agreement will be governed by the State of Illinois' current agreement with the American Federation of State, County and Municipal Employees (AFSCME). Positions are established by the IDCMS using a job description prepared by the employing agency. The description is used to classify the position and assign a payroll title. This determines the position's annual salary and determines whether the position is subject to a collective bargaining agreement.

The position descriptions submitted with the original proposal for MIECHVP and this application were prepared from specifications developed and approved by IDCMS and serve as the basis for establishing and classifying these positions. Each job description specified the education and work experience required to successfully carry out the position's responsibilities. The Project Director's position is classified as a Senior Public Service Administrator and so is exempt from the U.S. Supreme Court's *Rutan* decision<sup>13</sup> (which forbids the consideration of political affiliation in personnel decisions).

Local staff. Recruitment, selection, hiring, compensation and other personnel actions are the responsibility of the community-based organizations that will be selected to implement the home visiting programs. Local agencies will be required to provide job descriptions and, when possible, resumé's, for positions in their home visiting programs and the management staff who will be responsible for administration of the program. These documents will be reviewed by IDHS staff and the other members of the Strong Foundations Partnership selection committee to ensure that they meet the requirements established by the developer of the model (or developers of the models) that the

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<sup>13</sup> *Rutan v. Republican Party of Illinois*, 497 U.S. 62 (1990)



community has chosen to implement. Agencies implementing NFP will collaborate with NSO personnel, as required by the proprietary implementation agreement.

High Quality Supervision. The Executive Committee’s understanding of and commitment to reflective supervision was presented in Section 4, under “Clinical Supervision and Reflective Practice.”

Capacity of Local Organizations. IDHS’ RFP will ask local organizations to describe their current and prior experience in serving families with young children in general and home visiting in particular. Organizations with extensive experience are given more weight with regard to that aspect of their proposals.

Referral and service Networks. Please refer to “Coordination of Ancillary Services” in Section 4 for the state’s plan to ensure that families in home visiting programs will be able to access the additional services that they require.

Monitoring of Fidelity. Please refer to “Ensuring Implementation with Fidelity” in Section 3 for the state’s plan to monitor fidelity to the national model.

Coordination with the State Advisory Council on Early Education and Care. Illinois’ proposal for funds to support the State Advisory Council on Early Education and Care, as authorized by 642B(b)(1)(A)(i) of the Head Start Act, identified six goals. The plan is being implemented by the Governor’s Office of Early Childhood Development (OECD) and the Early Learning Council (“the Council”). The MIECHVP directly pertains to goals 1, 3, 4 and 5.

The six goals are:

1: Engage Vulnerable Children and Families in High-Quality Early Childhood Education: To achieve this goal, the Council and the OECD are testing strategies to engage “hard-to-reach” children and families in early care and education. The goal of this demonstration project is to increase the participation of high-need, hard-to-reach populations of children in all Illinois state- and federally-funded quality early care and education programs. MIECHVP will contribute to this effort through the development and testing of a community system for universal screening.

2: Increase Early Childhood Facilities in Underserved Communities: To achieve this objective, the OECD and the Council are providing organizations and municipalities with technical assistance on capital projects to help them successfully apply for state funding for the building and renovation of early childhood education and care centers in underserved communities.

3: Increase Community Collaborations and Partnerships: To achieve this goal, the OECD and the Council’s Community Systems Development Work Group is supporting local community partnerships in serving young children and their families by raising awareness about the importance of community collaboration and partnerships as well as providing local technical assistance to build strong systems and partnerships in Illinois communities. The Work Group will achieve this priority objective through the following three goals in the coming three years: (1) fund a technical assistance support system to establish new and strengthen existing local community collaborations and systems; (2) establish designated public funds to support local community collaboration efforts; and (3) build on the network of community level collaborative systems across Illinois. The efforts of the Council and the MIECHVP to develop integrated early childhood service delivery systems in the target communities will complement one another to achieve this goal.

4: Early Childhood Data System: To support these efforts, the OECD and the Council will develop and begin to implement a plan to create a unified early childhood data system that integrates current systems and provides new data on Illinois’ birth-to-five programs. This early childhood data system will provide access to data and information related to education, health, and human services data systems, giving a comprehensive picture of early childhood programs and services for young children and families in Illinois. The coordinated system will connect and improve data related to children, early childhood programs, and providers from individual records housed within multiple public and private agencies, and provide a unified data set with differing levels of access to end users for research, policy, and practice purposes

5: Birth-to-Three Monitoring System: To address this priority, the OECD and the Council will support state-funded home visiting programs in completing their respective national program model's credentialing process. The programs supported by MIECHVP will be required to complete the certification process prescribed by the model developer. The work of the Council and of the MIECHVP will complement one another and contribute to the achievement of this priority.

6: Strengthen Illinois' Professional Development System: The OECD and the Council will strengthen Illinois' professional development system in two important ways: increasing opportunities for early childhood practitioners to obtain their credentials, and implementing two Intensive Faculty Institutes to better prepare teachers to meet the needs of all Illinois children. By addressing these key barriers, the Council will further Illinois' professional development system to prepare a well-qualified workforce. The specific, three-year goals of this priority objective are to: (1) provide additional funding to the Illinois Gateways to Opportunity Scholarship Program<sup>14</sup> to increase opportunities for practitioners who are working to increase their expertise in early childhood education; and (2) provide Intensive Faculty Institutes for early childhood and bilingual higher education faculty members to develop strategies for effectively preparing the early childhood workforce. This goal is primarily focused on early care and education.

State Early Childhood Comprehensive Systems (SECCS) Initiative Strategic Plan. The implementation of MIECHVP is the first objective in Illinois' SECCS Strategic Plan. MIECHVP will also contribute to the achievement of several other objectives in the SECCS plan, including:

- Activities 3 and 4 under Objective 1.2 ("Develop and implement a system of referral and coordination to ensure children who may be at-risk for a developmental delay or disability receive appropriate referral to preventive child development services and programs") through the linkages that will be established between home visiting programs and providers of ancillary services;
- Objective 1.3 ("Support the development and implementation of systems to build and sustain local community partnerships") through the early childhood service networks that will be established in the target communities;
- Objective 1.4 ("Advance recommendations for the development of an enhanced and coordinated monitoring system for government-funded Infant-Toddler programs") by requiring that local programs maintain certification by model developers and by collection of data on program fidelity;
- Objective 1.6 ("Ensure early childhood programs and staff meet the needs of culturally and linguistically diverse young children") through staffing, training and appropriate adaptation of curricula; and
- Objective 1.8 ("Develop a strategy regarding implementation of school readiness assessments in Illinois") through the collection of data for Benchmark #4 ("Improvements in school readiness and child academic achievement").

**Compliance with Model-Specific Prerequisites.** IDHS and the other members of the Executive Committee will work closely with the model developers to ensure that prerequisites for each model are met. IDHS has been implementing and monitoring Healthy Families Illinois programs for 14 years. Four models – PAT, NFP, Healthy Steps and Early Head Start – require local organizations to prepare and submit a program plan for review and approval by the model developer. IDHS will use these guidelines to ensure that the materials required by the model developers are included in the RFP that will be issued to select an implementation agency. The proposal submitted by each community will also be forwarded to the appropriate state or national office to initiate this process. In this way, IDHS will ensure that proposed programs are designed to meet national standards before funds are awarded.

**Changes to State Administrative Structure.** Illinois' administrative structure for MIECHVP was described in Section 1 and at the beginning of this section. No changes to the administrative structure have been made since the original application was submitted in July 2010. Illinois' Acting Title V Director and other IDHS staff worked closely with Region V staff from the Maternal and Child Health Bureau to clarify the administrative structure. These discussions culminated in the Organization Chart that is included in the Appendices of this Implementation Plan.

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<sup>14</sup> <http://www.ilgateways.com/>

**Collaborations Established with Other Early Childhood Initiatives.** The Division of Community Health and Prevention at IDHS is responsible for the administration of several special early childhood initiatives, as well as on-going programs that serve families with young children.

Two of the communities in the cluster on the south side are served by the Greater Englewood Healthy Start Initiative and the third community in that cluster is served by IDHS' Chicago Healthy Start Initiative. Two of the communities (Elgin and Macon County) are served by one of IDHS' All Our Kids Early Childhood Networks. Two of the Target Areas are also served by one of DCHP's Targeted Intensive Prenatal Case Management programs. This initiative targets communities with elevated rates of low birth weight and uses a variety of strategies to engage at-risk women early in pregnancy and ensure that they have access to prenatal care and other health and human services.

All of the Target Areas are served by IDHS' state-wide programs for families with young children, including WIC (the Special Supplemental Nutrition Program for Women, Infants and Children); Early Intervention (Part C of the Individuals with Disabilities Education Act), Family Case Management (a state-funded program to reduce infant mortality), Family Planning (which is supported with federal Title X funds) and Teen Parent Services (which assists low-income teen parents with parenting, education and employment).

Children who are eligible to participate in Illinois' All Kids program also participate in Health Connect, a statewide Primary Care Case Management (PCCM) program for most persons covered by All Kids or FamilyCare.<sup>15</sup> Participants are assigned to a medical home through a Primary Care Provider (PCP), which ensures that clients have access to quality care from a provider who understands their individual health care needs. A client's PCP serves as his/her medical home by providing, coordinating and managing the client's primary and preventive services, including well child visits, immunizations, screening, and follow-up care as needed. Having a PCP also helps those with chronic conditions like asthma, heart disease or diabetes to get the treatment and ongoing care they need to minimize the need for hospital care. The PCP will also make referrals to specialists for additional care or tests as needed. There are currently over 1.9 million Illinois Health Connect clients with a PCP in a medical home. Information about the program is provided at [www.illinoishealthconnect.com](http://www.illinoishealthconnect.com).

### **Section 7: Plan for Continuous Quality Improvement**

Illinois' plan for MIECHVP includes a strong commitment to Continuous Quality Improvement (CQI). The Division of Community Health and Prevention already has extensive experience with this approach. More than a decade ago, Division staff launched a CQI effort to integrate the delivery of two state-wide programs for families with young children: the state-funded Family Case Management program, which was launched in the late 1980's to reduce Illinois' infant mortality rate, and the federally-funded Special Supplemental Nutrition Program for Women, Infants and Children. The effort to integrate the delivery of these programs was launched when program data demonstrated a significant improvement in infant mortality, low birth weight and very low birth weight rates when families participated in both programs. In addition to extensive technical assistance to local agencies, data in the form of a color-coded state map was distributed quarterly to all service providers. The maps shaded each county red, yellow or green depending on the degree of integration (cross-enrollment) between the two programs. The campaign continued for about two years until full integration had been achieved in almost all of the state, and new strategies were formulated to achieve additional progress. A similar approach was used to increase the rate of childhood immunization among WIC participants.

This section of the MIECHVP implementation plan will discuss the values underlying this approach to CQI, as well as the proposed structure, process and topics that may be considered through this effort. Topics for CQI of home visiting, universal screening and coordinated intake and the early childhood network are presented.

**Values Supporting CQI.** Two sets of values underlie the Executive Committee's approach to continuous quality improvement in the application of CQI to home visiting. The first set of values includes the assumptions that we make about the intentions of distressed families and why they participate in home visiting. We assume that new and expectant parents want to do the best job of parenting that they can. We assume that all families need both concrete

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<sup>15</sup> This IDHFS program provides coverage for parents and relatives who care for children under age 19.

and social supports in order to succeed as parents. Finally, we assume that distressed families – due to young age, social (as well as linguistic and cultural) isolation, depression, substance abuse, violence, homelessness, unemployment, limited education and other factors – need more practical and social support than other families and that this need can best be met through home visiting. One definition of quality in home visiting is the extent to which our home visiting programs meet or fail to address these needs.

The second set of values expresses the State's commitment to using data to improve quality and increase the benefits that families perceive and derive from the experience of participating in a home visiting program. We believe that every home visiting program staff member – whether an assessment worker, home visitor, supervisor, manager or other role – wants to do the best job that they can. We believe that the purpose of leadership at the state and local level is to equip, support and assist staff on the front lines to do their jobs well. We believe that the home visitors know the families, their circumstances and the challenges that families face better than anyone else involved in the program. We believe that they also understand the challenges of delivering the curriculum, supporting families and advocating on their behalf better than anyone else involved in the program. We also believe that gathering data about program operations to identify and solve problems can be an effective, efficient, supportive and instructive approach to improving the quality of home visiting.

**CQI Structure.** The basic structure supporting CQI is the creation of a team at the state level and a team within each program at the local level to use data to improve quality. At the state level, the Division of Community Health and Prevention already has a structure that promotes the use of data to improve quality. The Division refers to the traditional role of monitoring, technical assistance and consultation in public administration as “community support.” The Division has developed policies and procedures for assessment of quality at the provider and community levels, followed by the delivery of supportive actions (through training, consultation, technical assistance, networking and other strategies) to address identified needs. This process is supported by Division management through the quarterly review of performance on a large set of metrics developed by the Division's program managers. Reports are produced at the provider and regional levels on a quarterly basis. These reports are analyzed by IDHS program staff and recommendations are forwarded to program and regional managers for discussion at a quarterly meeting. The outcome of this meeting is the formulation of a support plan, the identification of resources and the assignment of responsibility to implement the plan. Healthy Families Illinois programs are already reviewed through this process; programs supported through MIECHVP can easily be added.. CQI data are also reviewed by the NFP NSO at the national level, and reviewed with local sites by the NSO's Nurse Consultant assigned to the site.

Thus, the core team that is supporting a local home visiting program includes staff from the Division's office of Program Planning and Development, which manages the Division's information systems and prepares the reports, the Community Support Services Consultant who is designated as the provider's primary liaison with the Division, the Bureau Chief for Child and Adolescent Health, who will be managing the local program grants made with MIECHVP funds, and a masters-prepared Maternal and Child Health Nursing Consultant who can assist the staff with questions about implementation of program models.

At the local level, home visiting program staff will be encouraged and expected to work as a team in using the data that they collect about the operation of their program to improve its quality. The team will be encouraged to meet monthly so that the use of data to understand, review and improve the quality of home visiting services becomes a routine part of program operations.

**CQI Process.** Implementation of the CQI process will begin with training of local project staff in the values, structure and procedure of CQI. This training may be obtained formally or provided by DCHP's regional staff.

Once the local projects have hired staff and training has been completed, the state and local project staff will meet to develop a specific CQI implementation plan for the project. This meeting will result in the establishment of priorities for data analysis (which aspects of program operation will be examined first), the data that will be collected to analyze the problem and recommended target levels. Final decisions on performance targets will be made by DCHP project managers. This process will be repeated no less than annually. Since the implementation agencies haven't been selected yet, we don't know how much experience they will have with the operation of home visiting services. If the implementation agencies are experienced, the full team will reconvene after a few CQI

cycles to consider the selection of new topics. If the implementation agencies are inexperienced, the team will reconvene after a few cycles to review progress to date, determine if the performance targets were realistic, consider new targets and continue the process for more cycles. In this way, IDHS will use CQI to improve the quality of the CQI process.

Following the selection of topics and the establishment of targets, data collection will begin. This will be monitored at both the local and state levels. The production of CQI reports will begin after a month of data collection. The initial review at both the state and local levels will not only examine performance but also consider the completeness of data collection. Reports will be distributed among the state level CQI team members for each project, all of the local projects, the members of the Executive Committee and the model developers. Data will be analyzed by program and by home visitor to promote both transparency and accountability.

The reports will be reviewed both separately and jointly by the state and local CQI teams. The joint review will include the DCHP Community Support Services Consultant or the Maternal and Child Health Nursing Consultant assigned to the project, or both. The reviewers will seek to understand the data by asking the local project staff to interpret it. Emphasis will be placed on understanding what high-performing agencies and home visitors are doing to achieve a high level of performance. This may identify best practices that can be disseminated to other MIECHVP program sites and other home visiting programs. All of the review team members will be encouraged to approach the review as an opportunity for learning, problem-solving and identifying opportunities for improvement and skill-building.

The review will culminate in an action plan. This may involve changes in procedure, changes in data collection, identification of the need for additional training or technical assistance or another strategy for improving performance. Local home visiting program staff will then implement the plan and data collection will continue. Local program staff will prepare a written summary of the interpretation and the action plan. This will be disseminated to everyone who received the performance data.

As the last step in the process, the team will reconvene to examine the data, determine if performance improved, meet with the sites to understand the data, identify any additional assistance that may be needed to improve performance, and then formulate and implement a new plan of action. This cycle will continue until the performance has improved and will begin again with the selection of a new performance topic.

Consultation with Model Developers. The Executive Committee consulted with the model developers while preparing the implementation plan to understand their approaches to monitoring and quality assurance. The models vary in the frequency and content of their monitoring and CQI activities. The NFP collects and reviews data on a monthly basis and conducts an annual review on-site. HFI performance data is already reviewed each quarter by IDHS staff and conducts an annual on-site review. Staff from the PAT state office visit new programs between three and six months after training to formulate a technical assistance plan. Consultation is then provided by telephone or electronic mail. The PAT state office also offers an on-site review of model implementation. The Director of Healthy Steps at Advocate Health Care observes service delivery, meets with the Specialists on a monthly basis and provides on-going training and technical assistance. Early Head Start programs submit monthly and semi-annual reports that are reviewed by the federal regional office. EHS sties also submit an annual self-study and participate in a triennial on-site review. The state-level team will work closely and coordinate efforts with model developers in order to complement, rather than duplicate, the monitoring, consultation, technical assistance and quality assurance activities of the national models' program offices.

**Objects of CQI.** Many aspects of operating a home visiting program must be examined to ensure that the program is operating with fidelity to the national model and meeting the needs of participating parents. These topics, which reflect the project's logic model, are presented below. Each topic includes a discussion of the variables that will be examined.

The Home Visitor. The qualifications, skills, training and cultural competence of the home visitor are fundamental to successful delivery of the intervention. This topic will include the home visitor's qualifications and completion of model-specific training, his or her mastery of the skills conveyed through training (including helping, teaching and advocacy skills) and cultural competence. The Illinois Birth To Three Institute has developed a framework of

paraprofessional home visitor competencies which are covered through the institute's training programs. The framework will also be used to examine the home visitor's competence and identify the need for additional training. Additional consultation with the NFP NSO will occur to ensure that the nurse home visitors hired by NFP programs have the qualifications, skills, training and cultural competence required by the NSO.

The Occurrence of the Home Visit. This is the core mechanism for delivering family support, parenting education and service coordination to families. This topic includes the location of the visit (in what setting does the visit actually occur?), the timing of the visit (are visits occurring at the family's convenience?) the frequency of visits (are they occurring as often as the model prescribes?), the length of each visit, the duration of the family's participation in home visiting and the reasons for termination from services. The standards established by each model developer will be used as the basis for ensuring that families are receiving the appropriate "dosage."

The Content of the Home Visit. This is the essence of the intervention. This topic includes use of time during the visit (how is time distributed among: parent-child activities; child health, development and well-being; parent health, development, well-being, education and employment; planning; screening and other activities?). It will also include the family's perceived value of the curriculum and its cultural appropriateness. The home visit will also be used to screen families for problems such as emotional disturbance (perinatal depression), substance misuse, intimate partner violence, access to medical care, health insurance coverage and other topics). (Screening for intimate partner violence will be conducted privately to ensure that screening does not trigger additional violent behavior.) Finally, the home visit will be used to review and revise each family's individual service plan. The home visitor and the family will review referrals that have been made, those that have been completed, barriers to service access and strategies to overcome these barriers.

The Home Visitor / Family Relationship. The quality of this relationship is essential for successful service delivery. This topic will include an examination of racial, ethnic, cultural and language compatibility between the family and the home visitor, as well as the use of the Working Alliance Inventory (also used in the national cross-site evaluation of model fidelity in the "Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment" grant).

The Management of Home Visiting. This aspect of CQI will focus on the operation of the home visiting program. It will include examination of caseloads; the frequency, length and content of supervision; the recruitment, selection and retention of staff; the establishment, maintenance and effectiveness of the program's relationship with other community organizations (especially the providers of essential ancillary services); and affiliation with and accreditation by the model developer. Program operations will be compared to the model developer's standards.

Families. Several attributes of participating families will be considered in CQI. This will include an examination of recruitment (the referral sources, the number and characteristics of families referred [compared with program capacity and special capabilities] and the timing of referrals (to determine that they are being received within the time required by the model). "Special capabilities" include program characteristics such as the availability of bilingual staff. "Timing" refers to referral during the prenatal period (for models such as NFP), immediate postpartum period (for models like HFI) or later (for models such as PAT and EHS.) Finally, families' social, economic, demographic and cultural characteristics will be compared to those of the community and the target population for which the model was designed to ensure that the program is reaching its intended audience.

The Consequences of Home Visiting. The "benchmarks" discussed in Section 5 of this Implementation Plan will also be used in CQI to ensure that the program is having the effects expected from prior research on the model employed.

Universal Screening and Coordinated Intake. As this approach is developed and tested, data will also be used to determine whether all new or expectant parents in the target area have participated in the screening process, that the use of multiple home visiting programs is coordinated and that families are directed to the community services they desire, if the need for them is identified during screening and intake. This component of Illinois' MIECHVP has several aspects.

*Outreach.* This topic will examine the outreach activities conducted by screening agency and its relationships with the organizations that are common points of entry for families. These entry points include providers of family planning and prenatal care, hospital obstetrical units and newborn nurseries, providers of preventive health care and nutrition services (such as WIC), and other organizations that serve families with young children. These relationships are essential for ensuring that home visiting programs are supplied with an adequate number of families. Data on the number of families referred from each source, the appropriateness of these referrals and the screening agency's relationship with each agency will be examined through the CQI process. The number of new or expectant parents who are screened for services will be compared with the number of births in the target area to determine whether screening is "universal." For this part of the CQI process, the team will expand to include staff from the home visiting programs in addition to the screening agency, IDHS and other members of the Executive Committee.

*Screening.* This CQI topic will include the number of problems or conditions to be identified through screening, the qualifications and training of staff who are administering and interpreting screening instruments, and the number of families who are being screened and the number of families who are being identified with each of the conditions or in each of the circumstances that are the subject of screening.

*Referral to Home Visiting.* The initial focus of universal screening and coordinated intake will be the distribution of families among the home visiting programs in the community. This CQI topic will examine the relationship between the screening agency and each of the home visiting programs; whether each agency can identify a contact person at the other; the execution of a Memorandum of Understanding; the number of families referred to each provider compared to the home visiting agency's capacity and specific target population; the distribution of families among home visiting programs; the number of families referred to each home visiting program who subsequently enroll in services; and the reasons that referrals are declined when families do not enroll in home visiting.

*Referral for Ancillary Services.* As the screening and intake system becomes established for home visiting, it will be expanded to include other community services. Similar to the variables that will be examined for referral into home visiting, this CQI topic will examine the relationships that the screening agency has with ancillary service providers; the formality of these relationships (whether each identify a regular contact person at the other agency and whether a Memorandum of Understanding been executed between the organizations) the number of families referred, the number of referrals completed and the reasons that services were declined if the family does not enroll.)

Early Childhood Network. Consultation to strengthen each community's early childhood collaboration will be tailored to each community. CQI indicators will be developed during the process of consultation and technical assistance.

### **Section 8: Technical Assistance Needs**

The Executive Committee requests technical assistance with the following aspects of implementing the MIECHVP:

- The development of an integrated information system that supports all of the home visiting models and assistance in negotiating data sharing agreements with national model developers;
- Identifying and preparing for the implementation of significant adaptations of the national evidence-based models, such as adaptations to address the needs of families affected by emotional disturbance, substance abuse, domestic violence, parental developmental delay, homelessness or limited English proficiency;
- Designing and implementing a universal screening and coordinated intake system;
- Designing and implementing strategies to develop parent leadership in home visiting programs and community early childhood systems; and
- Establishing policy regarding the relationship between home visiting programs and the criminal justice system.

### **Section 9: Reporting Requirements**

The Illinois Department of Human Services will comply with the legislative requirement for submission of an annual report to the Secretary regarding the activities carried out under the Maternal, Infant and Early Childhood Home Visiting program.

The report shall include the following: Progress on State Home Visiting Program goals and objectives, Update on Promising Approaches, Update on experience in Implementing Home Visiting programs in the Targeted

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Community(ies), Progress toward achievement of the Legislatively-mandated Benchmarks, Update on the program's CQI efforts, Update on the Administration of the Home Visiting program, Additional Technical Assistance needs